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ABSTRACT

This interdisciplinary curriuclum is intended as a framework for teaching a families course. It is designed to be used with graduate students studying early intervention work with families of young children with disabilities. The curriculum attempts to provide students with information related to family theory, research, policy, and law with direct application for working with families. It provides students with opportunities to apply this information to their own experiences as family members and as professionals working with families, and opportunities to engage in interdisciplinary discussions and activities. The instructional objectives covered in the curriculum are at the knowledge and attitude levels, rather than at the behavioral level. Section I provides an overview of the development of the curriculum. Section II contains the course syllabus and eleven 3-hour modules. Each module is described in terms of student objectives (either knowledge-based or attitude-based), suggested readings, and suggested student activities. The 11 modules cover: a rationale for an interdisciplinary approach to early intervention, family theories, family adaptation, models for an empowering approach to families, the family as members of the team, identification of family resources and concerns, collaboration in goal setting and intervention, communication strategies, and service coordination. Section III contains course and student evaluation information. Section IV provides a bibliography of approximately 100 references. Appendices contain a list of student competencies for working with families in early intervention, figures and tables for reproducing overheads, and training materials related to the student activities. (JDD)

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Working WITH Families IN Early Intervention:

AN INTERDISCIPLINARY PRESERVICE CURRICULUM

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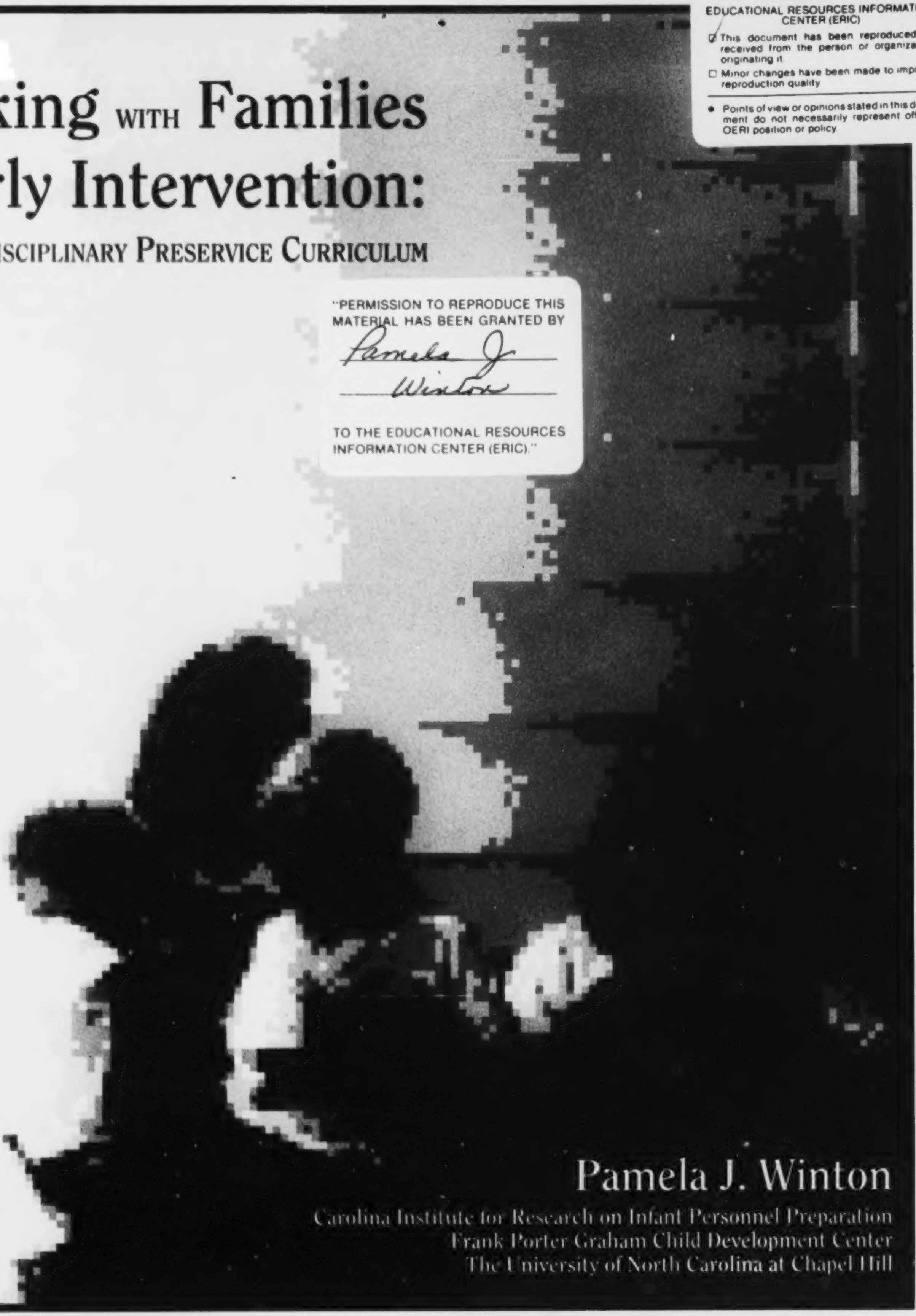

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*Working With Families in Early Intervention: An Interdisciplinary Preservice Curriculum,
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Organization of the Manual

The manual is divided into five sections. Section I, Background and Overview of the **Curriculum**, provides an overview of the development of the interdisciplinary families curriculum. Section II of the manual contains the Course Syllabus and Modules. Each module is described in terms of 1) student objectives, identified as being either knowledge-based (K) or attitude-based (A); 2) suggested readings; and 3)suggested student activities. Section III contains course and student Evaluation information. Section IV is the **Bibliography**. Section V is the **Appendix**. The Appendices contain a list of student competencies for working with families in early intervention, figures and tables for reproducing overheads, and training materials related to the student activities.

This curriculum is intended as a framework for teaching a families course. The content has been defined in terms of 11 three hour modules which basically comprise a semester-long course. Faculty using the manual will probably want to expand and modify in ways that work best for them and their students. Other curricula related to working with families in early intervention that may be helpful are listed below:

Turnbull, A. P., & Sergeant, J. (1990). *Instructor's Manual to accompany Families, professionals and exceptionality: A special partnership* (2nd ed.). Columbus, OH: Merrill Publishing Co. P.O. Box 508, Columbus, OH 43216.

Kilgo, J., Clarke, B., & Cox, A. (1990). *Interdisciplinary infant and family services training: A professional training model.* Richmond, VA: Virginia Institute for Developmental Disabilities, Virginia Commonwealth University, 301 W. Franklin Street, Box 3020, Richmond, VA 23284-3020.

SECTION I:

Background & Overview

Best Practices

Working in partnership with families and other professionals has become a primary mission for early interventionists. Although different labels have been used to describe this interdisciplinary focus on families, including family-focused intervention (Bailey, Simeonsson, Winton, Huntington, Comfort, Isbell, O'Donnell, & Helm, 1986), family-centered care (Shelton, Jeppson, & Johnson, 1987), and family enablement and empowerment (Dunst, Trivette, & Deal, 1988), certain central assumptions are shared across models and disciplines. These include the following:

1. Family-centered: We recognize that the family is the constant in the child's life while the service systems and personnel within those systems may be involved only episodically.

2. Ecologically-based: In our work with families we need to consider the interrelatedness of the various contexts which surround the child and family.

3. Individualized: Since the needs of each child and each family may differ, services should be individualized to meet those unique needs.

4. Culturally sensitive: Families come from different cultures and ethnic groups. Families reflect their diversity in their views and expectations of themselves, of their children and of professionals. Services should be provided in ways that are sensitive to these variations and consistent with family values and beliefs.

5. Enabling and empowering: Services should foster a family's independence, existing and developing skills, and sense of competence and worth.

6. Needs-based: A "needs-based" approach starts with a family's expressed interests and collaborates with families in identifying and obtaining services according to their priorities.

7. Coordinated service delivery. Families need access to a well-coordinated system of services.

8. Normalized: Programs work to promote the integration of the child and the family within the community.

9. Collaborative: Early intervention services should be based on a collaborative relationship between families and professionals.

Public Law 99-457

The passage of Public Law 99-457 in 1986 established a firm philosophical as well as functional basis for an interdisciplinary family-centered approach in early intervention. This law was stregthened through its subsequent reauthorization: In 1990 it was renamed The Individuals with Disabilities Education Act (IDEA), and in 1991 P. L. 102-119 reauthorized the infant and toddler component of the law (known as Part H) by creating more family-centered language and requirements for how services are to be provided. Philosophically, this legislation emphasizes the interrelationships among children, families and community services. They establish family support and interdisciplinary collaboration as key goals for early intervention services. Specifically they require a team approach for assessment and program planning that includes family members as the primary decision makers.

Personnel Preparation

One of the key components to programs under IDEA being successfully implemented is the preparation of qualified personnel to carry out the legal mandate. Unfortunately recent surveys of existing personnel have indicated severe shortages in the field (Meisels, Harbin, Modigliani, & Olsen, 1988; Yoder & Coleman, 1990). These personnel shortages will likely increase because of the demands for expanded services required by the legislation. An additional concern relates to the extent to which early intervention professionals are adequately trained to implement the law before entering the work force. A series of surveys carried out through the Carolina Institute for Research on Infant Personnel Preparation (CIRIPP) suggests that existing preservice training programs within many of the disciplines most closely associated with early intervention are currently providing little specialized content in the areas of working with families or in interdisciplinary contexts (Bailey, Simeonsson, Yoder & Huntington, 1990). What is more alarming is the evidence that existing preservice programs are not likely to be expanded or changed in order to address the personnel needs generated by the IDEA legislation (Bailey, et al., 1990; Gallagher & Staples, 1990). A major barrier to program development and expansion identified in this literature was lack of qualified faculty.

Need for Preservice Families Curriculum

The data reported above suggests the need for curriculum material to aid faculty members who may be asked to teach courses or modules related to working with families in early intervention and who may not have the background, knowledge and skills to comfortably do so. Information from the Bailey et al., 1990, paper indicated that to ensure maximum usage, materials should be designed in ways that promote flexibility and modifications.

Curriculum Development

The interdisciplinary families curriculum was developed and field tested from 1988–1992 on the University of North Carolina at Chapel Hill (UNC-CH) campus under the auspices of the Carolina Institute for Research on Infant Personnel Preparation (CIRIPP) and with the assistance of Institute staff and faculty (see cover sheet for acknowledgements). The presence of an interdisciplinary Institute faculty provided an opportunity to develop a curriculum that was truly interdisciplinary in focus. In addition, the participation of Institute faculty in field-testing maximized the possibilities that the core semester-long curriculum might form the basis for modules or other curricula designed specifically for disciplinary preservice training programs.

An original version of the curriculum was field-tested in 1989 in a semester long course with graduate students (n=23) and faculty (n=18) representing the following 12 disciplines: audiology, developmental psychology, medicine, nursing, nutrition, physical therapy, public health, occupational therapy, social work, speech/language pathology, special education, and school psychology. Revisions were made, based primarily on feedback from this group, and the current curriculum was field-tested in 1990 (n=20), 1991 (n=27), and 1992 (n=26) with interdisciplinary groups of graduate students.

Content

A set of core competencies based on assumptions and roles that cut across the key disciplines and derived from current literature defining best practices in working with families of children with disabilities (Bailey & Simeonsson, 1988; Dunst, Trivette & Deal, 1988; Turnbull & Turnbull, 1990) was developed by the author in 1988. The competencies are defined in terms of specific conceptual (knowledge), perceptual (attitude) and behavioral (practice) skills. (See Appendix A for a list of these competencies). These competencies were the basis for the curriculum that was field tested in 1989.

The interdisciplinary group of faculty and students who field-tested the curriculum were asked to prioritize content areas. Feedback from this group involved reducing the amount of time spent on theory and increasing the amount of time on information related to practice. This feedback was used to reformulate the curriculum in terms of content emphasis.

Because the curriculum only addresses coursework related to working with families and does not include information for planning and supervising practicum placements, the instructional objectives covered in the curriculum are at the knowledge and attitude levels. In order to address behavioral skills, opportunities for repeated practice and feedback are necessary (McCollum, 1982). An integrated training experience in which coursework and practicum placements are coordinated has been described as essential in preservice training of teachers (McCollum, 1982) and human service providers (Anthony, Cohen, & Farkas, 1988). It is recommended that the core competencies listed in Appendix A be used to coordinate the families curriculum with practica sites. In addition, student activities that promote application of ideas to clinical settings and practice sites have been included in the curriculum.

It is important to emphasize that working with families is a complex process that goes far beyond what can be covered in one semester. The curriculum provides a solid base for further training.

Recommended Instructional Method

Although content is clearly an important component of any curricula, instructional methods for conveying content play an important role in achieving long-range and higher level goals for students (McKeachie, Pintrich, Lin & Smith, 1986). Because a primary goal during the 1989 field-testing, in addition to achieving identified student outcomes, was to facilitate discussion among the interdisciplinary group of faculty and student participants in order to further curriculum development, some thought was given to which instructional methods might accomplish this. A decision was made that the author and guest lecturers would act primarily as facilitators of discussion rather than lecturers/instructors. The field-test data indicated that the peer learning and teaching that resulted from this instructional strategy was one of the most valuable aspects of the course. Therefore, during the 1990 field-testing of the revised curriculum, a similar teaching method was used. This discussion-oriented approach has much in common with the student-centered approach described by McKeachie, et al., 1986. The following dimensions of the student-centered approach described by McKeachie et al., 1986, characterized the instuctional strategy used:

1. Student-student interactions are encouraged;
2. Student participation and discussion are encouraged and emphasized;
3. Instructor accepts rather than criticizes or rejects erroneous or irrelevant student contributions;
4. Tests and grades are de-emphasized.

Data from the 1990 field-testing indicated that students responded positively to this instructional approach. (See Evaluation section).

Several factors related to the content of the curriculum add to the strength of these data in encouraging the use of a student-centered instructional approach. First, the emphasis on family support is new. There is a strong possibility that the approach to families being promoted in the curriculum is not being supported in other university courses or being implemented in practica sites where students may be placed. This creates a challenge for students as they try to reconcile conflicting ideas and information. Providing opportunities for discussion and for disagreement allows students a chance to air these concerns in a supportive atmosphere. It makes it more likely that the ideas and information will be internalized as students interpret what they are seeing in practica sites, reading in the literature, and hearing in courses within the context of the family support movement.

Second, in spite of broad-based agreement that family support is important, different disciplines have different theoretical and practice traditions related to working with families. These differences are reflected in the variability across disciplines in terms of time devoted to infancy and family content in preservice training programs (Bailey, et al., 1990). For instance, the ecological model for providing services with a focus on families has been a part of the social work curriculum since 1901 (Weil, & Karls, 1985); this concept is a relatively new one for other disciplines. This suggests that students from different disciplines may enter a families course together with different levels of preparation. In addition, graduate students within the same discipline may differ greatly in terms of work experience and background training (Bailey et al., 1990). The student-centered approach facilitates the sharing of these different perspectives and knowledge. It provides an opportunity to demonstrate that each discipline and each individual may be uniquely prepared with different strengths and weaknesses for working in early intervention.

Third, there are disciplinary differences in terms of basic terminology used in early intervention. Words like "intervention" or "case management" can mean different things to different disciplines. Terminology and acronyms understood within one discipline leave students from other disciplines staring blankly. A student-centered approach increases sensitivity to the use of jargon and encourages the development of a shared definition of words and terms.

Finally, the evolving nature of how to best implement the ideas associated with the family support movement make discussion a critical component to a families curriculum. There is no one model or set of procedures or skills that have been defined for providing family support. Therefore, encouraging students to become actively involved in their own learning through discussion of issues may encourage them to take a leadership role in helping the agencies in which they will soon find positions define and implement a more family-centered approach.

Integrating the Case Study Method of Instruction

During 1991 a version of the curriculum integrating the Case Method of Instruction was field-tested with an interdisciplinary group of graduate students (n=27). The Case Method of Instruction is a strategy in which realistic cases, for which there is no one obvious solution, are given to students. The instructor facilitates discussion or other activities which guide the students through the process of generating a course of action that they would take if they were professionals working with the family. The cases and activities used were from *The Families We Serve,* written by P. J. McWilliam who also served as co-instructor of the course. More information about the Case Study Method is available in *The Families We Serve,* including guidelines for using cases in training, student activities related to the cases, a matrix suggesting specific cases that are particularly relevant to various family content areas, and 8 case studies. Although evaluation data is not yet available from this effort, preliminary feedback indicates that students are positive about the experience.

Target Audience

Ideally this curriculum would be offered to an interdisciplinary group of graduate students. However, there are barriers to attracting an interdisciplinary group including: 1) student schedules being filled with core courses required by their respective disciplines; 2) lack of resources, such as faculty, because their time is taken up by other commitments and priorities; 3) difficulty in scheduling a course that does not present a time conflict with the numerous practica placements and disciplinary coursework; and 4) lack of administrative support, in general, for interdisciplinary collaboration. The rewards for overcoming these barriers are evident from the student evaluations. When asked the open-ended question, "What is the best part of this course?", the majority of students include something about learning from different disciplines. Given the difficulties in gathering an interdisciplinary group, the target audience for a curriculum such as this one may be early childhood special education graduate students. Special education has been identified as being in a strong position to respond to the personnel preparation initiatives called for by the IDEA legislation (Gallagher & Staples, 1990). Even without the presence of students from a variety of disciplines, the interdisciplinary focus embedded in the curriculum should provide students from a single discipline with information helpful in preparing them for working in an interdisciplinary fashion.

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Bailey, D. B., Simeonsson, R. J., Yoder, D., & Huntington, G. (1990). Preparing professionals to serve infants and toddlers with handicaps and their families: An integrative analysis across eight disciplines. *Exceptional Children, 57*(1), 26-35.

Dunst, C., Trivette, C., & Deal, A. (1988). *Enabling and empowering families: Principles and guidelines for practice.* Cambridge, MA: Brookline Books.

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SECTION II

Course Syllabus & Modules

Course Syllabus

Broad Objectives

1. To provide participants with information related to family theory, research, policy and law which has direct application for working with families of young children with disabilities.

2. To provide participants with opportunities to apply this information to their own experiences as family members and as professionals working with families.

3. To provide participants with opportunities to engage in interdisciplinary discussions and activities related to working with families in early intervention.

Recommended Texts and Readings

1. Bailey, D. B., & Simeonsson, R. J. (Eds.). (1988). *Family assessment in early intervention*. Columbus, OH: Merrill Publishing Co.

2. Dunst, C., Trivette, C., & Deal, A. (1988). *Enabling and empowering families: Principles and guidelines for practice.* Cambridge, MA: Brookline Books.

3. Johnson, B. H., McGonigel, M. J., & Kaufmann, R. K. (Eds.). (1991). *Guidelines and recommended practices for the individualized family service plan* (2nd ed.). Bethesda, MD: Association for the Care of Children's Health.

   or

   Johnson, B. H., McGonigel, M. J., & Kaufmann, R. K. (Eds.). (1989). *Guidelines and recommended practices for the individualized family service plan.* Washington, DC: Association for the Care of Children's Health.

4. Turnbull, A. P., & Turnbull, H. R. (1990). *Families, professionals, and exceptionality: A special partnership* (2nd ed.). Columbus, OH: Merrill Publishing Co.

Content Outline

INTRODUCTION

Introductory Module—Introduction to the course (rationale, broad goals, format, assignments and evaluation strategies); Pre-course student outcome measures (see Section III); Introduction of course content related to an ecosystemic paradigm for understanding intervention with families and a brief overview of P. L. 99-457 and its subsequent reauthorization.

Module 1—Developing a rationale for an interdisciplinary approach to early intervention

THEORETICAL PERSPECTIVES

Module 2—Family theories: Systems and life cycle perspectives

Module 3—Family adaptation: Impact of child and family factors

Module 4—Family adaptation: Impact of culture, community, and intervention

Module 5—Developing an empowering approach to families: Models of helping

APPLICATIONS TO PRACTICE

Module 6—Application of principles to practices: The Individualized Family Service Plan and the family as members of the team

Module 7—Application of principles to practices: Collaborating with families in child assessment

Module 8—Application of principles to practices: Identifying family resources, priorities and concerns

Module 9—Application of principles to practices: Family-professional collaboration in goal-setting and intervention

Module 10—Interviewing and communication strategies for identifying family priorities and resources

Module 11—Service Coordination

Introductory Module
Course Overview

Participant Objectives

1. Participants will know the structure and format for classes, expectations for participants, and other general information related to the course (K).
2. Participants will demonstrate knowledge of an ecosystemic paradigm as a way of understanding broadly the interrelationships between "at risk" young children, families, the social, cultural and political environments and the role of early intervention. (K)
3. Participants will espouse the belief that an individualized approach to service delivery, which takes into account the context in which the child resides, is the most effective approach. (A)

Readings

1. Ooms, T. (1990). *Implementation of 99-457: Parent/Professional Partnership in Early Intervention*. Family Centered Social Policy: The Emerging Agenda, Washington: AAMFT. pp. 6-11.
2. Jeppson, E. S. (1988). Parents take priority in family-centered care. *Family Resource Coalition Report, 7*(2).
3. Guralnick, M. J. (1991). The next decade of research on the effectiveness of early intervention. *Exceptional Children, 58*(2), 174-183.

Supplemental Readings

1. Hauser-Cram, P., Upshur, C., Krauss, M. W., & Shonkoff, J. (1988). Implications of Public Law 99-457 for early intervention services for infants and toddlers with disabilities. *Social Policy Report*, III(3).
2. Healy, A., Keesee, P. D., & Smith, B. S. (1985a). Early development. In *Early services for children with special needs: Transactions for Family Support* (pp. 15-32). Iowa City, Iowa: Univ. of Iowa Hospitals and Clinics, Department of Pediatrics.
3. Healy, A., Keesee, P. D., & Smith, B. S. (1985b). Early intervention: Themes for services. In *Early services for children with special needs: Transactions for*

family support (pp. 1-13). Iowa City, Iowa: Univ. of Iowa Hospitals and Clinics, Department of Pediatrics.

4. Turnbull, A. P., & Winton, P. J. (1984). Parent involvement policy and practice: Current research and implications for families of young, severely handicapped children. In J. Blacher (Ed.), *Severely handicapped children and their families: Research in review* (pp. 374-395). New York: Academic Press.

Suggested Teaching Activities

1. The instructor may want to show the videotape, "Family-Centered Care for Children with Special Health Care Needs".* Participants could be asked to identify assumptions, principles, ideas about intervention that are illustrated or defined in the video, as they watch it. They could also be asked to consider the extent to which the video addresses issues related to cultural diversity. These observations could provide the basis for a large group discussion.

2. As a result of the discussion, the instructors may want to focus on the following main ideas:

    a. **Ecological perspective:** Show overhead of diagram (see Appendix J, p. AA) and discuss different contexts or elements surrounding child and interdependence of different contexts.

    b. **Policy/legal/sociohistorical context:** Brief overview about current policy as reflected in IDEA legislation. Describe law in terms of Part H (see Appendix J, p. BB) and Part B and emphasize why this is considered to be such far reaching legislation. (Emphasize state and local autonomy and status of different states in regard to implementation).

    c. **Family-centered approach:** Not only does this make sense, this is now part of public policy. What does this mean? Is it the same as parent involvement? Are professionals ready for this?

    d. **Interdisciplinary/interagency focus:** Not only does this make sense, this is now part of public policy. What does it mean? How can it be accomplished?

    e. Rationale for this interdisciplinary families course has been outlined above. Most of us receive discipline-specific training related to children. This is an opportunity to broaden our knowledge-base and to consider issues related to working together with children and families that cut across each of our disciplines.

    f. Explanation of Organization of Course Modules

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*Video available from Association for the Care of Children's Health,, 7910 Woodmont Ave., Suite 300, Bethesda, MD. Telephone number (301) 654-6549 or FAX (301) 986-4553.

Module 1
Developing a Rationale for an Interdisciplinary Approach to Early Intervention

Participant Objectives

1. Participants will be able to describe briefly the major roles on the early intervention team of the following disciplines: special education, psychology, speech/language pathology, occupational therapy, physical therapy, audiology, social work, nursing, medicine, and nutrition. (K)

2. Participants will be able to describe briefly three models of disciplinary teaming. (K)

3. Participants will be able to describe briefly the dimensions of individual characteristics, group characteristics, group process and situational factors that impact team dynamics. (K)

4. Participants will espouse the belief that early intervention is not the work of a single discipline but must be conducted in collaboration with other disciplines in order to be effective. (A)

Readings

1. Thurman, S. K., & Widerstrom, A. H. (1990). *Infants and young children with special needs: A developmental and ecological approach.,* (2nd ed.*)* (pp. 222-230). Baltimore, MD: Paul H. Brookes Publishing Co.

2. Nash, J. (1990). P. L. 99-457: Facilitating family participation in the multidisciplinary team. *Journal of Early Intervention, 14*(4), 318-326.

3. Dunn, W., & Staff. (1990-1, Winter). Service provision challenges of team work. *Transitions*, 1-4.

4. Dunn, W., & Staff. (1990-1, Winter). Training for interdisciplinary team work. *Transitions,* 8-11.

Supplemental Readings

1. Bailey, D. B., Palsha, S. A., & Huntington, G. S. (1990). Preservice preparation of special educators to serve infants with handicaps and their families: Current status and training needs. *Journal of Early Intervention, 14*(1), 43-54.

2. Bailey, D. B., Simeonsson, R. J., Yoder, D. E., & Huntington, G. S. (1990). Preparing professionals to serve infants and toddlers with handicaps and their families: An integrative analysis across eight disciplines. *Exceptional Children, 57*(1), 26-35.

3. Crais, E. R., & Leonard, C. R. (1990). P. L. 99-457: Are speech/language pathologists prepared for the challenge? *Asha, 32*(4), 57-61.

4. Cochrane, C. G., Farley, B. G., & Wilhelm, I. J. (1990). Preparation of physical therapists to work with handicapped infants and their families: Current status and training needs. *Journal of Physical Therapy, 70*(6), 372-380.

5. Holditch-Davis, D. (1989). In light of P. L. 99-457, how well are novice nurses prepared? *In Touch 7*(2), 5.

6. Humphry, R., & Link, S. (1990). Entry level preparation of occupational therapists to work in early intervention programs. *American Journal of Occupational Therapy, 44*(9), 828-833.

7. Kaufman, M. (1989). Are dietitians prepared to work with handicapped infants? P.L. 99-457 offers new opportunities. *Journal of the American Dietetic Association, 89*(11), 1602-1605.

8. Golin, A., & Ducanis, A. (1981). The team and the exceptional child. In *The interdisciplinary team: A handbook for the education of exceptional children* (pp. 1-11). Rockville, MD: Aspen Publications.

9. McCormick, L., & Goldman, R. (1979). The transdisciplinary model: Implications for service delivery and personnel preparation for the severely and profoundly handicapped. *AAESPH Review, 4*(2), 152-161.

10 Center for Educational Development. Team dynamics and the decision-making process. In *Project BRIDGE: Decision-making for early services: A team approach* (pp.42-58). Elk Grove Village, IL: American Academy of Pediatrics.

Suggested Teaching Activities

1. Through a panel presentation and large group discussion centered around a case vignette (the Mack family could be used; see Appendix J, p. CC), representatives of selected disciplines might describe the typical role on an early intervention team of professionals from their disciplines. They will present the following information related to the case vignette:

    a. their typical broad role *vis a vis* the team and the family (consultant, direct service provider, service coordinator, etc.);
    b. their role in child assessment (context, measures used, mechanisms for reporting results)
    c. their role in identifying family priorities and resources
    d. their role in developing an intervention plan
    e. their role in implementation of that plan

    If time permits, they will then be asked to describe changes in their roles and functions that might result if changes in the case illustration were made (i.e., the child and family were seen in a different setting because of change in age or handicapping condition).

2. Prior to class a matrix listing the questions identified above could be created on the flipchart. During the presentation, this information could be recorded on a flipchart. During the panel the responses of individual disciplines could be recorded on the flipchart.

3. Class discussion might focus on the impact on the family of many different professionals needing to interact with child and family, the impact of different models of disciplinary teaming on families, and teaming strategies that are supportive to families.

4. An overhead of the Project BRIDGE chart (see Appendix J, p. DD) will be shown to highlight and summarize comments related to individual characteristics, group characteristics, group process, and situational factors that impact team dynamics and family-professional relationships.

Note: When selecting panel representatives, it is helpful to select professionals who actually provide direct services. It may also be helpful to discuss this class session at the beginning of the class the following week. This gives students a chance to reflect on the experience. The following questions might be addressed:

a. Do you feel you got a better understanding of other professional disciplines? your own?

b. Did the panelist accurately represent your discipline? What additional information would you have liked for the class to have heard about your discipline? What additional information would you have liked about other disciplines?

Module 2
Family Theories:
Systems and Life Cycle Perspectives

Participant Objectives

1. Participants will demonstrate knowledge of three key components of family systems and life cycle theories (subsystems, boundaries, and hierarchies) and their implications for intervention with families. (K)

2. Participants will espouse the belief that the young child is best understood in the context of the family, and change or intervention directed at one family member affects every other member. (A)

3. Participants will describe how changes over time (development) of illness/disability, individual, and family systems interact and can influence family functioning. (K)

4. Participants will espouse the belief that an individualized approach to intervention with families that is sensitive to ongoing changes in the development of the illness, the individual, the family system, and the social context is most effective. (A)

Readings

1. Foster, M., Berger, M., & McLean, M. (1981). Rethinking a good idea: A reassessment of parent involvement. *Topics in Early Childhood Special Education, 1*(3), 55-65.

2. Rolland, J. (1987). Chronic illness and the life cycle: A conceptual framework. *Family Process, 26*, 203-221.

3. May, J. (1991). Commentary-What about fathers? *Family Support Bulletin*, p. 19.

Supplemental Readings

1. Minuchin, P. (1985). Families and individual development: Provocations from the field of family therapy. *Child Development, 56*, 289-302.

2. Aponte, H. J. (1986). "If I don't get simple, I cry". *Family Process, 25*, 531-548.

3. Andrews, J., & Andrews, M. (1990b). The systemic perspective. In *Family-based treatment in communicative disorders* (pp. 5-22), Sandwich, IL: Janelle Publishing.

4. Turnbull, A. P., & Turnbull, H. R. (1990). Family interaction. In *Families, professionals and exceptionality: A special partnership (*2nd ed.*)* (pp. 52-76). Columbus, OH: Merrill Publishing Co.

Suggested Teaching Activities

1.*Family Sculpture Project: Students might be asked to do this project for homework. For some students this assignment may be difficult, especially if they are in the middle of a family crisis. It is important to stress that sharing the information will be on a voluntary basis. Students will need colored construction paper, glue, scissors and pens in order to do this project. Refer to the Wedemeyer and Groterant (1982) article for pictorial examples of this project.

OBJECTIVES OF PROJECT

- To provide students with an opportunity to apply the basic concepts of family systems theory to their own family
- To provide students with a context for discussing the family system concepts

DIRECTIONS FOR STUDENTS

1. Decide what family you will picture (family of origin or current family). If you have more than one family for some reason, you may do both.

2. Trace and cut out circles from the construction paper, making enough for yourself and each person or set of persons or things you want to include. There are no restrictions on whom you include or how you symbolize them. (Parents, siblings, neighbors, pets, your father's golf game, whoever or whatever has a significant effect on the family.) If you wish you may vary size, shape or color of the units to express yourself more fully.

3. Label each circle. A single circle may have one name or more than one if you see those people/things as a unit.

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*Wedemeyer, N., & Groterant, H. (1982). Mapping the family system: A technique for teaching family systems theory concepts. *Family Relations*, 31, 185-193.

4. Arrange the circles on a large piece of colored paper so they express the relationships you feel in your family. When you feel comfortable with the total arrangement, firmly glue them in place.

5. Draw any boundary or connecting lines you feel complete the picture.

6. Please bring your project to class if you feel comfortable doing so. Volunteers will be asked to share their sculpture.

CLASS DISCUSSION OF PROJECT

1. Students might be divided into small groups, making sure that at least 1 student in each group is willing to share their family sculpture. In these groups the volunteers will be asked to discuss their Family Sculpture Project in terms of subsystems, boundaries, and hierarchies. Participants in the small groups will be asked to consider the following questions:

   a. If a professional was providing early intervention services to your family, what information about subsystems, boundaries, and hierarchies would be helpful for them to know?

   b. What strategies would be effective for gathering this information with your family?.

   If time permits, the groups will share insights with the large group on different perspectives that emerged as a result of this project. One perspective that may emerge is that there are many different ways that the families of the participants in the class are structured. There is sometimes a tendency to define families with structures that are different from our own as being "abnormal," "dysfunctional," etc. Class discussion should highlight that these "differences" may be quite adaptive for individual families. This should lead to a discussion of value and cultural differences. This discussion will continue over the next two modules (and beyond).

2. Instructor might provide an overview of the key concepts of family systems theory and interaction with life cycle events covered in the readings and describe their implications for intervention (see Appendix J, p. EE). The following concepts and discussion questions could be presented:

   a. FAMILY SUBSYSTEMS—Every family can be considered to be a system made up of subsystems. Each subsystem is interdependent and interrelated. Individuals within the family have simultaneous memberships in a number of different subsystems. This way of looking at families is helpful because it depicts why intervention directed at only one member, or one dyad of a family system, impacts the whole system indirectly. The effects reverberate throughout the system. The following questions might be posed:

1. Who has been a traditional target of intervention efforts? (child or mother-child dyads)

2. What are possible outcomes of this narrow approach? (Might overemphasize parent-child subsystem and subsequently compromise mother's role and child's role in other family subsystems; might put pressure on mothers to increase their caretaking and educational functions . . . it is important to consider how this will impact other important family functions such as recreational. If intervention goals are set with only one part of family system, other members of system will not be likely to support those goals. This diminishes chances of goals being met.)

b. FAMILY BOUNDARIES—Families have metaphorical lines or boundaries that define the subsytems within the family (internal boundaries). In addition, there is a metaphorical line that defines who is "in" and who is "not in" the family (external boundaries).

Internal boundaries: The discussion above highlights how intervention might affect internal boundaries (cite examples given in above discussion). The Rolland article describes how a disability might affect internal boundaries. The following questions might be posed:

1. How do internal boundaries change in response to life cycle events? How do disruptions in life cycle events created by disability impact internal boundaries?

2. What is impact of supporting or supplanting internal boundaries through intervention efforts?

External boundaries: Some families have rigid external boundaries and this will affect relationships with outside helpers. In Module 4 we will discuss further the impact of intervention on families...both positive and negative consequences.

    c. FAMILY HIERARCHIES—This basically means who is in charge in this family;...who has power and authority. Cite examples of unexpected sources of family power,...(i.e., the ghost of a dead relative). The following question might be posed: Why is it important to consider which family members have power and authority?

    d. INTERACTION OF CONCEPTS—Several types of development occur simultaneously: child's individual development; family as it evolves in its own life cycle; and changing course of physical condition and unfolding adaptation to it. All of this is influenced by social context and cultural variations. Refer back to ecological model.

2. Family Vignette Activity: Participants could read the Crowder family vignette (Appendix C) and address the questions in the case vignette activity before class.

   Large group discussion might take place as part of instructor's presentation. Participants will be encouraged to consider the Crowder family and the Aponte case illustration. They might be asked to consider the following:

    a. Describe the Crowders in terms of the following concepts: parental and sibling subsystems, hierarchies, internal and external boundaries, life cycle events, developmental events associated with family illness. What information from Hannon family (Aponte case) helps us understand Julie Crowder?

    b. How does this information affect how you might conduct intervention with them? Where would you start and how?

Module 3
Family Adaptation: Impact of Child and Family Factors

Participant Objectives

1. Participants will identify child and family characteristics that impact parent-child interactions. (K)

2. Participants will be able to describe at least one theory of family adaptation to stress and its implications for intervention. (K)

3. Participants will espouse the belief that understanding the interaction between the characteristics of the child and the family, including family values, beliefs, daily routines, and existing resources, is an important component in planning effective intervention with families. (A)

Readings

1. Wright, J., Granger, R., & Sameroff, A. (1983). Parental acceptance and developmental handicap. In J. Blacher (Ed.), *Severely handicapped young children and their families: Research in review* (pp. 51-86). Orlando: Academic Press.

2. Turnbull, A. P., & Turnbull, H. R. (1990). Family support: Helping families cope. In *Families, professionals and exceptionality: A special partnership (*2nd ed.*)* (pp. 361-384). Columbus, OH: Merrill Publishing Co.

3. Wieder, S. (1989). Mediating successful parenting: Guidelines for practitioners. *Zero to Three, 10*(1) 21-22.

4. Kaiser, C., & Hayden, A. (1984). Clinical research and policy issues in parenting severely handicapped infants. In J. Blacher (Ed.), *Severely handicapped young children and their families* (pp. 275-312). Orlando: Academic Press.

5. Winton, P. (1990). Promoting a normalizing approach to families: Integrating theory with practice. *Topics in Early Childhood Special Education, 10*(2), 90-103.

Supplemental Readings

1. Trout, M., & Foley, G. (1989). Working with families of handicapped infants and toddlers. *Topics in Language Disorders, 10*(1), 57-67.

2. Fraiberg, S., Adelson, E., & Shapiro, V. (1975). Ghosts in the nursery. *Journal of the American Academy of Child Psychiatry, 4*(3), 387-421.

Suggested Teaching Activities

1. The instructor may want to show a segment of a videotaped interview with a parent & child.* The students could be asked to make note of child characteristics, family characteristics, family beliefs, values and existing resources that they feel are conveyed in the video. [Perhaps they will use a framework, such as ABCX, which is described in the Winton (1990) article, for making notes].

2. Following videotape, there could be a discussion of what participants noted. The following points from the readings could be highlighted by the instructor:

   a. Family variables from readings over last two weeks (systems, life cycle, functions) could be summarized and reviewed (see Appendix J, p. EE).

   b. Theories and models of family adaptation may be briefly reviewed and summarized–
      1) Hill's ABCX Model, which is described in Winton (1990) article (see Appendix J, p. FF)
      2) Olson's research, which is summarized in Turnbull & Turnbull, 1990 chapter (see Appendix J, p. GG)
      3) Farber's theory of minimal adaptation (see Appendix J, p. HH)

   What do these theories and models tell us about ways to define family strengths on IFSP?

   It should be noted that much of the family research has been conducted with middle-class Ango families. For instance, much of Olson's research was carried out with 1000 Lutheran families in the mid-west.

   c. Focusing on caregiver-infant relationships in intervention – Can this be done in ways that support families or support what is being done well?

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*There are several portions of the "Family-Centered Care" videotape used in the Introductory module which feature interviews with mothers and fathers. One of those segments could be used.

Module 4
Family Adaptation:
Impact of Culture, Community, and Intervention

Participant Objectives

1. Participants will define features of their own family ecology (available resources, family values and cultural heritage) that impact the way family life is organized (i.e., daily routines and task allocation). (K)
2. Participants will recognize that personal values and biases affect definitions of family strengths. (A)
3. Participants will espouse the belief that to maximize effectiveness, intervention efforts must fit into and be sustainable within the daily routines, values, and beliefs of families. (A)

Readings

1. Gallimore, R., Weisner, T., Kaufman, S., & Bernheimer, L. (1989). The social construction of ecocultural niches: Family accommodation of developmentally delayed children. *American Journal on Mental Retardation, 94*(3), 216-230.
2. Affleck, G., Tennen, H., Rowe, J., Roscher, B., & Walker, L. (1989). Effects of formal support on mothers' adaptation to the hospital-to-home transition of high-risk infants: The benefits and costs of helping. *Child Development, 60*, 488-501.
3. Darling, R. B. (1989). Using the social system perspective in early intervention: The value of a sociological approach. *Journal of Early Intervention, 13*(1), 24-35.
4. Hanson, J. J., Lynch, E. W., & Wayman, K. I. (1990). Honoring the cultural diversity of families when gathering data. *Topics in Early Childhood Special Education, 10*(1), 112-131.

Supplemental Readings

1. Kazak, A. E., & Wilcox, B. L. (1984). The structure and function of social support networks in families with handicapped children. *American Journal of Community Psychology, 12*(6), 645-661.

2. Turnbull, H. R., & Turnbull, A. P. (1987). *The Latin American family and public policy in the United States: Informal support and transition into adulthood.* Lawrence, KS: The University of Kansas Department of Special Education and Bureau of Child Research.

3. Blau, M. (1989). In it together. *New York Magazine,* September 4 issue. (Genograms of famous people!), 44-54.

4. Norton, D. (1990). Understanding the early experience of Black children in high-risk environments: Culturally and ecologically relevant research as a guide to support for families. *Zero to three, 10*(4), 1-7.

5. Edmunds, P., Martinson, S., & Goldberg, P. (1990). *Demographic and cultrual diversity in the 1990s: Implications for services to young children with special needs.* Chapel Hill, NC: NEC-TAS.

6. Pollner, M., & McDonald-Wikler, L. (1985). The social construction of unreality: A case study of a family's attribution of competence to a severely retarded child. *Family Process, 24*(2), 241-254.

7. McGoldrick, M. (1982). Ethnicity and family therapy: An overview. In M. McGoldrick, J. Pearce, & J. Giordano (Eds.), *Ethnicity in family therapy* (pp. 3-30). New York: The Guilford Press.

Suggested Teaching Activities

1. **Identifying Family Strengths Activity:** Students could be asked to do this activity for homework. It is important to recognize that for some students the information generated through this activity may be sensitive. When making this assignment emphasize that sharing the information in class will be strictly voluntary.

OBJECTIVES OF ACTIVITY

- To provide students with information about variations between and among cultures
- To provide students with an opportunity to develop awareness of their own and others' family values and beliefs and possible cultural origins for these values
- To provide students with an opportunity to develop a definition of "family strengths" that is free of cultural bias

DIRECTIONS FOR STUDENTS

1. Please select the American ethnic group closest to your own ethnic heritage from the list generated from the McGoldrick, Pearce, and Giordana book referenced in Readings.

2. Please read the cultural profile on that ethnic group in the McGoldrick book.

3. Please answer (in writing) the following questions in terms of your own family:

   a. Identify at least one (try for more) family value or characteristic that you think would be important for an interventionist to know that might work with your family.

   b. Identify at least one internal coping strategy that you think your family uses in times of crisis (this can be unique to your family and not necessarily one identified in readings).

   c. To whom or where do you think your family typically turns for help when there is a crisis (external resources) and why? (See Appendix J, for an overhead which might be useful in discussing internal and external resources).

   d. Can you think of ways that family beliefs affect daily routines?

   e. How might your own family values and beliefs affect your work with families in intervention?

   f. How might it feel to have someone outside of your family tell you that something about your values, beliefs or routines would have to be changed? How would changes of this sort work for you?

   g. Think of and describe a recent accommodation that you have made as a result of a change in family ecology or life events.

CLASS DISCUSSION OF ACTIVITY

The questions above will guide class discussion in either small groups or a large group format. The following points might emerge in this discussion:

1. Ethnic background is **only one of many factors** that contribute to "culture". Provide two different definitions of culture that reflect this idea (see overhead with definitions in Appendix J).

2. Making assumptions about people based on limited knowledge can be misleading and not helpful in terms of developing positive relationships.

Module 5
Developing a Rationale for an Empowering Approach to Families in Early Intervention: Parent Perspectives and Models of Helping

Participant Objectives

1. Participants will be able to describe the principles and cite specific examples of an empowering approach to families in intervention and contrast the empowering approach with other models for providing intervention to families. (K)

2. Participants will espouse the belief that an empowering model for providing intervention to families is an effective one. (A)

Readings

1. Espe-Sherwindt, M., & Kerlin, S. (1990). Early intervention with parents with mental retardation: Do we empower or impair? *Infants and Young Children, 2*(4), 21-28.

2. NEC*TAS. (1990). Selected remarks from the NEC*TAS Parent Panel of the LRE Conference. In *NEC*TAS Resource Packet: Least Restrictive Environment for Infants, Toddlers, Preschoolers*. Chapel Hill, NC: NEC*TAS, CB# 8040, UNC-CH, Chapel Hill, NC 27599.

3. Vohs, J. R. (1989). Perspective: Vision and empowerment. *Infants and Young Children, 2*(1), vii-x.

4. Seitz, V., Rosenbaum, L. K., & Apfel, N. H. (1985). Effects of family support intervention: A ten-year follow-up. *Child Development, 56*, 376-391.

Supplemental Readings

1. Alexander, R., & Tompkins-McGill, P. (1987). Notes to the experts from the parent of a handicapped child. *Journal of Social Work*, 361-362.

2. Butler, A. (1983). There's something wrong with Michael: A pediatrician-mother's perspective. *Pediatrics, 71*(3), 446-448.

3. Turnbull, H. R., & Turnbull, A. P. (Eds.). (1985). *Parents speak out: Then and now* (2nd ed.). Columbus, OH: Merrill Publishing Co.

4. Featherstone, H. (1980). *A difference in the family: Living with a disabled child.* New York: Basic Books.

5. Dunst, C. J., Trivette, C. M., & Deal, A. G. (1988). Introduction. In *Enabling and empowering families: Principles and guidelines for practice* (pp. 1-11). Cambridge, MA: Brookline Books.

Suggested Teaching Activities

1. Invite a parent or parents to visit with the class and share their perspectives on early intervention practices. Resources for locating parents who may wish to participate the local chapter of the Association for Retarded Citizens or other parent advocacy organizations. If money is available to reimburse parents as consultants, this may make it easier for parents who must arrange childcare. It is also helpful to provide parents with the readings for this module in advance so that they can participate in the discussion.

2. Class discussion of presentation organized around the following questions:

    a. What messages come across in the parent presentation and articles related to parent perspectives?

    b. What principles/strategies/guidelines emerge related to an empowering approach to families or in addition to the three components of the empowering approach described by Dunst? What other principles emerge from the information provided by parents?

    c. Cite specific practices which were helpful (from parents' perspectives).

    d. Cite practices that were not helpful (from parent perspective). Do these practices fit into the other models of helping described in Dunst's Chapter 4?

Module 6
Application of Principles to Practices: The Individualized Family Service Plan and the Family as Members of the Team

Participant Objectives

1. Participants will be able to identify at least three assumptions underlying their future approaches to families in intervention settings. (A)
2. Participants will be able to identify at least four requirements specified in IDEA related to the content, participation, and implementation of the Individualized Family Service Plan. (K)
3. Participants will demonstrate knowledge of the 7 key components of the IFSP process. (K)
4. Participants will recognize that the process of generating an IFSP document is more important than the written document; therefore, there are a variety of IFSP formats that might be acceptable. (A)
5. Participants will recognize that families will vary in the ways and extent to which they wish to be involved in team meetings and IFSP development. (A)

Readings

1. Dunst, C., Trivette, C., & Deal, A. (1989). A family systems assessment and intervention model. In B. Hanft (Ed.), *Family-centered care: An early intervention resource manual* (pp. 259-265). Rockville, MD: AOTA, Inc.
2. Ziegler, M. (1989). A parent's perspective: Implementing P.L. 99-457. In J. J. Gallagher, P. L. Trohanis & R. M. Clifford (Eds.), *Policy implementation and P. L. 99-457* (pp. 85-96). Baltimore, MD: Paul H. Brookes Publishing Co.
3. McGonigel, J. J., Kaufmann, R. K., & Johnson, B. H. (1991). A family-centered process for the individualized family service plan. *Journal of Early Intervention 15*(1), 46-56.
4. Smith, S. W. (1990). Individualized education programs (IEPs) in special education. From intent to acquiescence. *Exceptional Children, 57*(1), 6-14.

5. Bailey, D. B., Buysse, V., Edmondson, R., & Smith, T. (1992). Creating family-centered services in early intervention: Perceptions of professionals in four states. *Exceptional Children., 58*(4), 298-310.

Supplemental Readings

1. Hanft, B. (1988). The changing environment of early intervention services: Implications for practice. *American Journal of Occupational Therapy, 42*(11), 26-33.

2. Sparks, S. (1989). Assessment and intervention with at risk infants and toddlers: Guidelines for the speech-language pathologist. *Topics in Language Disorders, 10*(1), 43-56.

3. Witt, J. C., Miller, C. D., McIntyre, R. M., & Smith, D. (1984). Effects of variables on parental perceptions of staffings. *Exceptional Children, 51*(1), 27-32.

4. Johnson, B. H., McGonigel, M. J., & Kaufmann, R. K. (Eds.). (1989). The IFSP sequence. In *Guidelines and recommended practices for the individualized family service plan* (pp. 11-21). Washington, DC: Association for the Care of Children's Health.

5. Johnson, B. H., McGonigel, M. J., & Kaufmann, R. K. (Eds.). (1991). Philosophy and conceptual freamework. In *Guidelines and recommended practices for the individualized family service plan* (pp. 5-10). Bethesda, MD: Association for the Care of Children's Health.

6. Johnson, B. H., McGonigel, M. J., & Kaufmann, R. K. (Eds.). (1991). An overview. In *Guidelines and recommended practices for the individualized family service plan* (pp. 1-4). Bethesda, MD: Association for the C[illegible] of Children's Health.

Suggested Teaching Activities

Because this module represents the transition from the more theoretical and philosophical part of the course to the applied component, it is important to plan activities that help students bridge that gap. The following ideas focus on trying to achieve that.

1. Ask students to start a journal, which they will keep for the remainder of the course. The first entry in the journal, which could be part of a class activity. is a list of four or five assumptions or principles related to working with families in early intervention which they believe in and which will guide their work with families. Encourage them not to parrot back what they have read, but to consider beliefs and ideas that they could implement in the reality of their current or future workplaces or practica sites. Ask them to write down underneath each assumption/principle what experience/reading/discussion, etc. made this idea become "their own" (i.e., one which they will act upon). These

principles will serve as the basis for additional journal entries and future class assignments.

2. Ask students to arrange an interview with an administrator from a school system or local agency involved in serving young children with special needs. The purpose of the interview is to ask how that system or agency is addressing the family-centered intent of the IDEA legislation. The students might want to consider ways of structuring this interview around the key issues or components of the law identified in their readings. Students could be advised to take written information to these professionals about the law (e.g., local or state information developed by Interagency Coordinating Councils), because in some cases the professionals' knowledge base may be limited. Students could be asked to comment in their journal on the extent to which the assumptions they identified as important were guiding existing practices, as described by administrators.

3. Class discussion of readings and interviews could focus on the following information:

    a. Key decision-making points (see Appendix J, p. PP) related to IFSP development (Bailey, Buysee, Edmondson & Smith, 1992)

    b. Barriers to change (Bailey, et al., 1992) and the students' potential role in the change process as they enter the field as young professionals

Module 7
Application of Principles to Practices: Collaborating with Families in Child Assessment

Participant Objectives

1. Participants will know Part H of the IDEA regulations related to the assessment of infants and toddlers. (K)

2. Participants will develop a rationale for collaborating with family members in child assessment, recognizing the potential advantages and limitations. (A)

3. Participants will recognize that family priorities should guide the child assessment process. (A)

4. Participants will identify a range of options for collaborating with families in the assessment of their children, citing principles and strategies likely to enhance their successful application. (K)

5. Participants will recognize that families may have different goals and priorities for their children from professionals, and will discuss approaches and strategies designed to resolve those differences in a mutually satisfactory fashion. (A)

Readings

1. Johnson, B. H., McGonigel, M. J., & Kaufmann, R. K. (Eds.). (1991). Assessment resources. In B. H. Johnson, M. J. McGonigel, & R. K. Kaufmann (Eds.), *Guidelines and recommended practices for the individualized family service plan* (2nd ed.) (pp. C1-C6). Bethesda, MD: Association for the Care of Children's Health.

2. Wolery, M., & Dyk, L. (1984). Arena assessment: Description and preliminary social validity data. *Journal of the Association for Persons with Severe Handicaps, 9*(3), 231-235.

3. Sheehan, R. (1988). Involvement of parents in early childhood assessment. In R. Sheehan & T. Wachs (Eds.), *Assessment of young developmentally disabled children* (pp. 75-90). New York: Plenum Press.

4. Kjerland, L., & Kovach, J. (1990). Family-staff collaboration for tailored infant assessment. In D.Gibbs & D. Teti (Eds.), *Interdisciplinary assessment of infants: A guide for early intervention professionals* (pp. 287-298). Baltimore, MD: Paul H. Brookes Publishing Co. Publishing Co.

5. Andrews, J., & Andrews, M. (1990a). Application to early childhood speech language, hearing problems. In *Family-based treatment in communicative disorders*. Sandwich, IL: Janelle Publishing.

Supplemental Readings

1. Bloch, J. S., & Seitz, M. (1989). Parents as assessors of children: A collaborative approach to helping. *Social Work in Education,* July, 226-244.
2. Parker, S. J., & Zuckerman, B. S. (1990). Therapeutic aspects of the assessment process. In S. J. Meisels & J. P. Shonkoff (Eds.), *Handbook of early childhood intervention* (pp. 350-369). Cambridge: University Press.

Suggested Teaching Activities

OBJECTIVE

To apply information from readings about collaborating with families in child assessment to the assessment process as it occurs in a real situation.

1. Have students identify a situation in which child assessments are conducted and carry out this assignment by conducting and/or observing the persons involved in these assessments. Ask them to address the following questions about the child assessment process in terms of a specific child and family with whom they have worked or with whom the persons they are observing/interviewing have worked. (If students are going to be observing an assessment, remind them that they will need to get the parents' permission).
    a. What was the purpose of the assessment? How was this decided and by whom?
    b. What assessment instruments were used and how were they selected?
    c. Where did the assessment occur (i.e., home, office, etc.)? How was this decided and by whom?
    d. Who was present for the assessment? How was this decided and by whom?
    e. Who conducted the assessment? How was this decided?
    f. How were the assessment results shared with others? Who received this information? Who decided who should know what?

   g. Do you consider the assessment you have just described as typical of the assessments conducted in the context you are in or are observing (clinic, school, hospital, etc.)?

   h. To what extent are the practices you observed consistent with principles underlying the family-centered intent of the IDEA legislation?

2. An alternative to observing a child assessment is to ask students to interview a professional who conducts child assessments as part of his/her work. The questions found on the following page (please feel free to reproduce for your students) are provided to help structure this interview. Students should be prepared that these questions may generate discussion and might want to share readings from class with professionals in order to disseminate ideas about best practice in conducting child assessments.

3. Ask students to write a brief report of their reaction to their observation/interview. If they have conducted an observation, this report could include the answers to the questions listed in #1. In both interview and observation situations, ask students to consider the extent to which they felt the principles/assumptions they identified in Module 6 were guiding the practices they observed.

	Never		Sometimes		Always
1. Do you conduct assessments at times that are convenient for families? Do you offer choices of times to parents?	1	2	3	4	5
2. Do you offer parents the option of conducting at least a portion of their children's assessments in their own homes?	1	2	3	4	5
3. Do you conduct observations of children in natural settings (i.e., home, daycare, classroom) as part of you assessment information?	1	2	3	4	5
4. Do you ask parents which professionals (disciplines) they want involved in the assessment of their children and do you honor their decisions?	1	2	3	4	5
5. Do you tell parents they may have anyone else they want present for, or involved in, the assessment(s) of their children (e.g., siblings, grandparents, friends, babysitters, professionals from other agencies)?	1	2	3	4	5
6. Do you offer parents choices regarding the assessment tools/measures that will be used for their child and the methods used for administration?	1	2	3	4	5
7. Do you offer parents a range of options for how they can be involved in the assessment of their children? Do you honor their decisions regarding the level or type of involvement they prefer?	1	2	3	4	5
8. Do you reveal and explain assessment results to parents immediately after they are obtained (i.e., on the same day)?	1	2	3	4	5
9. Do you offer parents a clear choice as to who assessment information will be shared with and how this will be done?	1	2	3	4	5
10. Do you discuss assessment results using terms that are readily understood and meaningful to parents?	1	2	3	4	5
11. Do you write children's assessment reports in such a way as to reflect the parents' priorities?	1	2	3	4	5
12. Do you write reports in a way that is readily understood and meaningful to parents?	1	2	3	4	5
13. Do you give a copy of your assessment report(s) to parents?	1	2	3	4	5
14. Do you offer parents the opportunity to write a portion of the assessment report(s), sign the report(s), or make suggestions for changes before a final copy is filed or sent out?	1	2	3	4	5
15. Do you clearly offer parents the opportunity for parents to be present at all discussions regarding the planning of the child's assessment or discussing the results of the child's assessment?	1	2	3	4	5
16. Do you only write recommendations in your assessment reports if they have been discussed with and agreed upon by parents?	1	2	3	4	5

[Reprinted from ***BRASS TACKS***. McWilliam, P. J., & Winton, P. J. (1990). Chapel Hill, NC: Carolina Institute for Research on Infant Personnel Preparation, Frank Porter Graham Child Development Center, The University of North Carolina at Chapel Hill].

Module 8
Application of Principles to Practices: Identifying Family Resources, Priorities and Concerns

Participant Objectives

1. Participants will provide a definition of family concerns and family resources. (K)

2. Participants will espouse the belief that effective intervention begins with how families define their situation, rather than with a presentation of services available. (A)

3. Participants will describe the major provisions of the IDEA legislation with respect to the assessment of family resources, priorities and concerns. (K)

4. Participants will identify a range of options for assessing family resources, priorities and concerns. (K)

5. Participants will recognize that families will vary in the ways and extent to which they wish to have family resources, priorities and concerns assessed. (A)

Readings

1. Summers, J. A., Dell'Oliver, C., Turnbull, A. P., Benson, H. A., Santelli, E., Campbell, M., & Siegel-Causey, E. (1990). Focusing in on the IFSP process: What are family and practitioner preferences? *Topics in Early Childhood Special Education, 10*(1), 78-99.

2. Kaufman, R. K., & McGonigel, M. J. (1991). Identifying family concerns, priorities, and resources. In B. H. Johnson, M. J. McGonigel, & R. K. Kaufmann (Eds.), *Guidelines and recommended practices for the individualized family service plan* (2nd ed.) (pp. 47-55). Bethesda, MD: Association for the Care of Children's Health.

3. Johnson, B. H., McGonigel, M. J., & Kaufmann, R. K. (Eds.). (1991). Resources for identifying family strengths, needs, resources, and support. In B. H. Johnson, M. J. McGonigel, & R. K. Kaufmann (Eds.), *Guidelines and recommended practices for the individualized family service plan* (2nd ed.) (pp. D1-D11). Bethesda, MD: Association for the Care of Children's Health.

4 Bailey, D. B., (1988a). Assessing family stress and needs. In D. B. Bailey & R. J. Simeonsson (Eds.), *Family assessment in early intervention* (pp. 95-118). Columbus, OH: Merrill Publishing Co.

5. Bailey, D. B., (1988b). Rationale and model for family assessment in early intervention. In D. B. Bailey & R. J. Simeonsson (Eds.), *Family assessment in early intervention* (pp. 1-26). Columbus, OH: Merrill Publishing Co.

6. Bailey, D. B., & Blasco, P. M. (1990). Parents' perspectives on a written survey of family needs. *Journal of Early Intervention, 14*(3), 196-203.

Suggested Teaching Activities

OBJECTIVE

To apply information from the readings about identifying family resources, priorities and concerns to the family assessment process as it occurs in a real situation.

1. Because the emphasis on the identification of family resources, priorities and concerns is fairly recent, many programs do not have clearly stated policies and procedures for doing this. In addition, best practice suggests that this activity is one that might take place over time and in a confidential and trusting atmosphere. For these reasons, asking students to observe the process may be unrealistic and intrusive for families. Therefore, it is recommended that students interview a professional rather than observing a family-professional interaction.

   The questions found on the last page of this module are provided to help structure this interview. Students might find that the professionals they interview are not aware of some of the ideas described in their readings. They might want to share some of their readings with professionals and emphasize that these ideas are new.

2. Ask the students to write a brief (one page) reaction to the interview, focusing on the extent to which they believe that the approach to families they "witnessed" (via interview) was consistent with the underlying principles/ assumptions they identified in Module 6.

3. Class discussion should focus on the following:

   a. Definitions of resources and priorities (see Winton (1990) article in Module 3 and Dunst, Trivette & Deal (1989) article in Module 6) and parent preferences for how that information is gathered (see Bailey and Blasco (1990) and Summers, et al., (1990) articles in this module);

b. Resources for gathering information on family resources, priorities and concerns (Johnson, et al., 1989, chapter in this module);

c. How the information in their readings related to best practice is consistent with their experiences and observations in the real world.

	Never		Sometimes		Always
1. Do you individualize your method(s) of gathering information (e.g., identifying needs & strengths) from each family?	1	2	3	4	5
2. Do you allow parents to determine how they will share information about themselves and their children (e.g., location, who will provide information, areas of information shared, form vs. personal interview)?	1	2	3	4	5
3. Do you tell parents exactly who will have access to the information they provide and how the information will be used (i.e., informed consent and confidentiality)?	1	2	3	4	5
4. Do you allow parents to withhold personal information about themselves if they so desire and are they informed that this is acceptable to the program staff?	1	2	3	4	5
5. Do you provide parents with information about resources available to meet goals they identify but that cannot be met by the services your program can offer (e.g., continuing education, marital counseling, financial assistance, employment)?	1	2	3	4	5
6. Do you have enough time available to develop a trusting relationship between parents and professionals in the process of gathering information and identifying child and family goals?	1	2	3	4	5
7. Do you show or give parents copies of reports released to your program from other agencies or professionals?	1	2	3	4	5
8. Do you give parents the option of not including reports from other agencies or professionals in their child's permanent file or do you allow parents to attach their own comments to the reports?	1	2	3	4	5
9. Do you tell parents about every contact (phone calls, face-to-face conversations) you have with people or agencies outside your program to obtain information?	1	2	3	4	5
10. Do you give parents control over what is written about them in your assessment reports (e.g., family status, family history, etc.)?	1	2	3	4	5
11. Do parents have an opportunity to read your reports before they are filed and request changes?	1	2	3	4	5
12. Can parents share personal information with one staff member without it being shared with other members of the team or written in your files?	1	2	3	4	5

[Reprinted from BRASS TACKS. McWilliam, P. J. & Winton, P. J. (1990). Chapel Hill, NC: Carolina Institute for Research on Infant Personnel Preparation, Frank Porter Graham Child Development Center, The University of North Carolina at Chapel Hill].

Module 9
Application of Principles to Practices: Family-professional Collaboration in Goal-setting and Intervention

Participant Objectives

1. Participants will develop a rationale for identifying goals and objectives for services provided. (A)

2. Participants will demonstrate knowledge of the issues associated with collaboratively establishing outcomes with families. (K)

3. Participants will espouse the belief that early intervention outcomes generated by families are more likely to be effectively achieved by families than outcomes generated by professionals. (A)

Readings

1. Bailey, D. B., (1987). Collaborative goal-setting with families: Resolving differences in values and priorities for services. *Topics in Early Childhood Special Education, 7*(2), 59-71

2. Kaiser, A. P., & Hemmeter, M. L. (1989). Value-based approaches to family intervention. *Topics in Early Childhood Special Education, 8*(4), 72-86.

3. Beckman, P. J., & Bristol, M. M. (1991). Issues in developing the IFSP: A framework for establishing family outcomes. T*opics in Early Childhood Special Education, 11*(3), 19-31.

4. Kramer, S., McGonigel, M. J., & Kaufman, R. K. (1991). Developing the IFSP: Outcomes, strategies, activities, and services. In B. H. Johnson, M. J. McGonigel, & R. K. Kaufmann (Eds.), *Guidelines and recommended practices for the individualized family service plan* (2nd ed.) (pp. 57-66). Bethesda, MD: Association for the Care of Children's Health.

5. Dunst, C. J. (1991). Implementation of the individualized family service plan. In B. H. Johnson, M. J. McGonigel, & R. K. Kaufmann (Eds.), *Guidelines and recommended practices for the individualized family service plan* (2nd ed.) (pp. 67-78). Bethesda, MD: Association for the Care of Children's Health.

6. Johnson, B. H., McGonigel, M. J., & Kaufmann, R. K. (Eds.). (1991). Sample IFSPs. In B. H. Johnson, M. J. McGonigel, & R. K. Kaufmann (Eds.), *Guidelines*

and recommended practices for the individualized family service plan (2nd ed.) (pp. A1-A66). Bethesda, MD: Association for the Care of Children's Health.

Supplemental Readings

1. Aponte, H. J. (1985). The negotiation of values in therapy. *Family process, 24,* 323-337.

2. Mental Health Law Project. (1990). Protecting children's and families' rights in Part H programs. *Early Intervention Advocacy Network Notebook,* Issue Paper #3.

3. Zygmond, M. J., & Boorhem, H. (1989). Ethical decision making in family therapy. *Family Process, 28,* 269-280.

Suggested Teaching Activities

OBJECTIVE

To apply information from readings about collaborative intervention planning to the planning process as it occurs in a real situation.

1. Have students identify a situation in which intervention planning is done (e.g., an IEP or IFSP meeting). If it could be arranged with the professionals and families involved, ask them if the student can sit in on this meeting. Ask the students to write a brief report on their reactions to this planning meeting. In structuring their observations and comments they might use the FOCAS scale excerpts on page 50 to rate what happened.

   In addition, ask students to comment on the extent to which what they observed was consistent with the principles of best practice they identified in Module 6.

2. An alternative to observing an IEP/IFSP meeting is for students to interview a professional who develops intervention plans with families as part of their work. This activity promotes the idea of intervention planning being an ongoing process, not one relegated to a once a year meeting. The questions from BRASS TACKS on page 51 are provided to help structure the interview.

   Ask students to write a brief reaction to their interview, focusing on the extent to which the practices they "witnessed" (via interview) are consistent with the best practice principles they identified in Module 6.

3. Class discussion should focus on the following issues:

   a. Why is it important to plan collaboratively with families (Bailey, 1988)?

b. What is different about intervention planning typically done in IEP meetings (might refer back to Turnbull & Winton (1984) article in Introductory Module for research on IEP meetings) and intervention planning being described in IFSP literature (Dunst, et al., 1988; Johnson, et al., 1989; Bailey, 1988)?

c. What skills/issues have been described in association with collaborative goal-setting (Bailey, 1987; Kaiser & Hemmeter, 1989; Zygmond & Boorhem, 1989)?

d. To what extent are these ideas about best practice consistent with what the students observed in the real world?

PARENT PARTICIPATION IN TEAM MEETINGS:

1	2	3	4	5	6	7	8	9
Parents attending the IEP/IFSP meeting are assigned passive role. Few efforts made to secure their input.		Parents participate to the extent that they take the initiative.		Parents are "given their turn" to contribute in team meetings.		Parents are encouraged and supported in taking an equal role with professionals in team meeting.		Professionals provide encouragement and support for parents who would like to lead team meeting.

PARENT ROLES IN DECISION-MAKING

1	2	3	4	5	6	7	8	9
Professionals write the IEP/IFSP & present it as a final document to parents for signatures.		Professionals present a plan for goals & services to parents & provide opportunities for feedback.		Professionals give parents opportunity to make suggestions for goals & services prior to writing the IEP/IFSP.		Professionals and parents work as equal partners in developing the IEP/IFSP.		Professionals provide support & encouragement for parents who would like to assume a leadership role in making decisions about goals & services.

[Reprinted from FOCAS: FAMILY ORIENTATION TO COMMUNITY AND AGENCY SERVICES. Bailey, D. B. (1990). Chapel Hill, NC: Carolina Institute for Research on Infant Personnel Preparation, Frank Porter Graham Child Development Center, The University of North Carolina at Chapel Hill].

	Never		Sometimes		Always
1. Do you offer parents the opportunity to be present at **all** discussions regarding intervention planning for their children and themselves?	1	2	3	4	5
2. Do you allow parents to determine who will be involved in developing the intervention plan and the format for their own involvement (e.g., large group meeting, home visit or center visit with one team member)?	1	2	3	4	5
3. Do you prepare parents for participating in the development of the intervention plan? Do you tell them the schedule of events, purpose, who will attend, the topics that will be discussed, and what they might do ahead of time?	1	2	3	4	5
4. Do you organize discussions of the intervention plan in a manner that is familiar and meaningful to the parents so that they are comfortable participating (e.g., using the family's own language/words; using daily routines or relationships as topics for developing interventions)?	1	2	3	4	5
5. Do you elicit information and ideas from parents in the development of the intervention plan?	1	2	3	4	5
6. Do you ensure that parents have access to all team members during the intervention planning process (e.g., to review assessment results, to discuss recommendations to ask questions)?	1	2	3	4	5
7. Do parents have ultimate decision-making power in arriving at a list of child and family goals and the methods that will be used to meet these goals?	1	2	3	4	5
8. Do you take into consideration the parents' natural support systems (e.g., extended family, friends, community groups, etc.) in developing intervention options to meet identified goals?	1	2	3	4	5
9. Do you offer parents options of services or resources to meet the intervention goals for their children? Do you honor parents' decisions regarding which services their children will receive or not receive?	1	2	3	4	5
10. Do you design interventions to fit the existing daily routines of the child & his or her family (i.e, nondisruptive)?	1	2	3	4	5
11. Are intervention plans written in a manner that is readily understood, meaningful, and useful for parents (in terms of both content and format)?	1	2	3	4	5
12. Do you have sufficient time available to develop a truly meaningful intervention plan and one that allows parents to be actively involved in its development?	1	2	3	4	5
13. Do you work together as a team in the development and writing of the intervention plan (across disciplines)?	1	2	3	4	5
14. Do you allow parents the option of not putting family goals (e.g., personal goals) in writing on the IFSP or IEP, even though you may be actively assisting them in achieving such goals?	1	2	3	4	5
15. Do you write the parents' names on the intervention plan as being responsible for implementation (where appropriate)?	1	2	3	4	5
16. Do you update intervention plans every three months (or more often) to reflect changes in goals or intervention strategies?	1	2	3	4	5
17. Do you have intervention plan (e.g., IFSP) forms that are easy to make changes on in order to reflect changes in child/family goals or intervention strategies?	1	2	3	4	5

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Module 10
Communication Strategies for Identifying Family Priorities and Resources

Participant Objectives

1. Participants will identify tasks associated with effectively beginning and ending an interview with a family. (K)

2. Participants will identify listening skills related to effective interactions with families. (K)

3. Participants will identify questioning skills related to effectively generating family priorities, alternative strategies for achieving outcomes and criteria for success. (K)

4. Participants will espouse the belief that all families, regardless of cultural or socioeconomic background, have resources that might be effective in achieving intervention outcomes and that the use of certain questioning skills is an effective strategy for identifying family priorities. (A)

5. Through participation in a videotaped role-play situation, participants will be able to identify at least one strength and one area for continued improvement for themselves as interviewers. (K)

6. Through participation in a videotaped role-play, participants should be able to identify one strength and one area of improvement in a fellow participant involved in the role-play. (K)

Readings

1. Winton, P. J. (1988a). Effective communication between parents and professionals. In D.B. Bailey & R.J. Simeonsson (Eds.), *Family assessment in early intervention* (pp. 207-228). Columbus, OH: Merrill Publishing Co.

2. Winton, P. J. (1988b). The family-focused interview: An assessment measure and goal-setting mechanism. In D. B. Bailey & R. J. Simeonsson (Eds.), *Family assessment in early intervention* (pp. 185-206). Columbus, OH: Merrill Publishing Co.

3. Bailey, D. B. (1991). Building positive relationships between professionals and families. In B. H. Johnson, M. J. McGonigel & R. K. Kaufmann (Eds.), *Guidelines*

and recommended practices for the individualized family service plan (2nd ed.) (pp. 29-38). Bethesda, MD: Association for the Care of Children's Health.

4. Murphy, A. (1990). Communicating assessment findings to parents: Toward more effective informing. In E. Gibbs & D. Teti (Eds.), *Interdisciplinary assessment of infants: A guide for early intervention professionals* (pp. 299-310). Baltimore, MD: Paul H. Brookes Publishing Co.

5. Winton, P. J., & Bailey, D. B. (in press). Communicating with families: Examining practices and facilitating change. In J. Paul & R. Simeonsson (Eds.), *Understanding and working with parents of children with special needs* (2nd Ed.). New York: Holt, Rinehart & Winston.

Supplemental Readings

1. Olson, J. (1988). *Delivering sensitive information to families of handicapped infants and young children.* Moscow, ID: University of Idaho.

2. Aponte, H. J. (1976). The family-school interview: An eco-structural approach. *Family Process, 15*, 303-311.

3. Cecchin, G. (1987). Hypothesizing, circularity and neutrality revisited: An invitation to curiosity. *Family Process, 26*(4), 405-413.

Suggested Teaching Activities

1. Class discussion summarizing the readings might focus on the following points:

    a. communication can be described in terms of both program practices and individual skills (Winton & Bailey, in press);

    b. specific communication skills (Winton, 1988a [see Appendix J, p. II] and a specific interview structure (Winton, 1988b see Appendix J, p. JJ) associated with effective interviewing have been identified in the early intervention literature.

2. Many students have had previous instruction in active listening and other traditional communication strategies. Before deciding upon teaching activities, it might be helpful to determine students' perceptions of their own training needs. The following activities are best suited for students wanting a review of basic listening skills:

a. LISTENING EXERCISE*: Ask students to pair up; it is best if students do not know their partner well. Provide each student with written instructions for this exercise. One partner in each pair (the interviewee) will receive the following written instructions:

> "Your partner is going to conduct a brief (3-5 minute) interview with you on the topic of how you got involved in early intervention. Please be as cooperative as possible."

The other partner in each pair (the interviewer) will receive the following written instructions:

> "You are to conduct a brief (3-5 minute) interview with your partner on the topic of how he/she got involved in early intervention. Please act interested at first then creatively think of ways to NOT LISTEN ATTENTIVELY to what he/she has to say."

At the end of the interview period ask the interviewees how they felt during the process. Ask interviewers to read their instructions aloud. Points that often emerge in this discussion include:

1. different ways of "not listening" (influenced by geographical and cultural differences);
2. how it feels to be "not listened to";
3. most students in the field of early intervention are fairly good listeners because of interest in "helping" relationships.

b. REFLECTING FEELINGS EXERCISE: In Appendix D are a series of comments that a parent might make in the context of receiving early intervention services. The instructor takes the role of the parent and reads the comment to the class. One student volunteer takes the role of the interviewer who makes less effective responses (First I: comment on Appendix D). The instructor then asks the students to write down a response that is an example of an accurate and sensitive reflection of the feelings expressed by the parent (Examples of accurate statements are the Second I: comment on Appendix D). The instructor asks students to share their responses on a volunteer basis. It is important to not criticize anyone's response, rather acknowledge that each response is a possibility and might elicit certain information. Ask the volunteer to consider if the response reflects the feelings of the parent.

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*Thanks to Shirley Geissinger for this idea.

Another approach is to ask the volunteer to take the role of the parent and repeat the parent comment. Ask another student to respond as the volunteer did. Ask the volunteer if he/she felt the response reflected the feelings he/she expressed.

This exercise provides students with concrete examples of statements reflecting feelings. By asking each student to write a response but asking for volunteer contributions, less skilled students are allowed a chance to assess their own limitations in this area without being embarrassed or humiliated. Depending upon the level of expertise in the class, volunteered statements may include the following: giving advice, making recommendations, reassuring, investigative questioning, etc. These examples provide an excellent teaching opportunity and highlight the extent to which professionals are trained to be "experts" rather than listeners.

3. **Class Demonstration of Questioning Skills:** For students who feel competent in basic skills, the focus for class demonstrations might best be on the more newly defined communication strategies, such as circular and reflexive questioning (Winton, 1988b; Winton & Bailey, in press). A scripted role-play is provided in Appendix E. This role-play provides a live demonstration of circular vs. linear questioning and reflexive vs. strategic questioning as described by Winton (1988a). To conduct this role-play, ask for volunteers to play the roles of father, mother, and interviewer. Give volunteers a chance to read through the scripts before the demonstration. At the end of each of the four segments, class discussion could focus on the following questions:

    1. What information was learned?

    2. What communication techniques were demonstrated and were they useful or not?

    A copy of questions that students might use in an interview situation in order to gather information and facilitate collaborative goal-setting are provided in the Appendices F & G. Students will find these helpful in preparing for the videotaped role-play activity associated with this module.

4. **Videotaped Family Role-play Activity** (see Appendix H): This activity provides students with a concrete and structured way of practicing communication skills, assessing their own strengths and needs, and providing peer feedback. It is most effective when done as a videotaped activity. If this is not possible, it can be done without videotaping.

5. Preparing for the videotaped family role-play activity can be the focus for another class activity. A rating scale has been developed for helping students with self-assessment and feedback associated with the interviewing skills (see Appendix H). Providing students with this rating scale and giving them practice in using it can be accomplished in class in several ways. Showing a videotaped

interview, especially one that is blatantly ineffective, and asking students to rate the interviewer is one strategy. Another strategy is to ask students to participate in a role-play activity in which students are divided into three groups: parents, interviewers and observers. The Miller Family Vignette is provided in Appendix I as a structure for conducting this class activity. The rating scale could be used as a vehicle for discussing this role-play activity.

Module 11
Service Coordination*

Participant Objectives

1. Participants will be able to define service coordination (formerly called case management) and describe the functions of the service coordinator under Part H of IDEA. (K)

2. Participants will be able to identify ways of maximizing parent/professional partnerships and interprofessional collaboration through the practice of service coordination. (K)

3. Participants will be able to describe some of the complex issues and challenges related to service coordination in early intervention. (K)

4. Participants will be able to define a variety of different approaches to service coordination in early intervention, and their advantages and disadvantages. (K)

5. Participants will be able to describe some of the issues to be considered in designing a system for service coordination. (K)

Readings

1. Bailey, D. B. (1989). Case management in early intervention. *Journal of Early Intervention, 13*(2), 120-134.

2. Dunst, C. J. (1989). An enablement and empowerment perspective of case management. *Topics in Early Childhood Special Education, 8*(4), 87-102.

3. Weil, M. & Karls, J. (1985). Historical origins and recent developments. In M. Weil, & J. Karls (Eds.), *Case management in human service practice* (pp. 1-29). San Francisco, CA: Jossey-Bass.

4. Zipper, I., Weil, M., & Rounds, K. (1991). *Service coordination for early intervention: Parents and professionals.* Chapel Hill, NC: Carolina Institute for Research on Infant Personnel Preparation, Frank Porter Graham Child Development Center, University of North Carolina.

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Suggested Teaching Activities*

1. The "Name Game" activity and discussion is a strategy for developing a definition of service coordination that is consistent with the spirit and intent of Part H of IDEA.

    A. Ask participants what the term "service coordination" (formerly called "case management") means to them. The different definitions given should demonstrate disciplinary and agency differences in terminology and language. Definitions might include the following: managing files and data, helping individuals who cannot help themselves, assisting people in understanding a complex institution, such as a hospital, etc. (See "The Name Game" overhead in Appendix J for a sample definitions).

    B. Present excerpts from the statute and regulations that pertain to service coordination (see Appendix J for sample overheads).

    C. The following definition of family-centered service coordination could be provided as one that is consistent with the intentions of Part H of IDEA: Family-centered service coordination is an on-going partnership with families that assists them in finding and accessing informal and formal supports that meet their changing needs and priorities (See Appendix J for overhead of definition).

    D. Participants could be asked to consider the following question: If this definition of service coordination were put into practice, what differences would it make for families and children, service providers and communities? (See Appendix K for worksheet for this question).

2. Providing information on different service coordination models is a strategy for providing information on how one might implement a family-centered approach in an early intervention setting. The information on models might be organized in terms of the following questions:

    A. Should the service coordination position be held by someone who is part of the early intervention program or someone who is independent of the early intervention program?

    Traditionally the position has been held by someone who is part of the early intervention program. (an "inside" approach) There are several variations within this model. The direct service provider assigned to the family may assume service coordination responsibilities as in the home visitor model; a "dedicated" service coordinator hired by the program may provide service coordination to all families; or in a transdisciplinary model,

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*These teaching activities were developed by Dr. Joicey Hurth, NEC*TAS and Dr. Irene Zipper, CIRIPP.

the team may decide who will serve as the service coordinator for each family based on their needs and desires. A contrasting approach is for full-time service coordination to be provided through another agency or through a private provider or program (an "outside" approach).

There are pros and cons to both approaches. The independent agency an "outside" approach may mean one **more** person with whom a family must interact and develop a relationship. However, the advantage is that person may have a broader understanding of community services (such as day care, health care, transportation, etc.) and may be more open to the perspective that families may have concerns that go beyond what the early intervention program has traditionally addressed.

B. If you choose an "inside" approach, who should perform the service coordination role?

C. Should experienced parents be trained and hired in the service coordinator role to work with other families, if they so desire?

3. To provide participants with an opportunity for discussion of pros, cons and issues related to each approach, "The Great Debate" activity could be held. (See Appendix L for the instructions for this group activity, which takes approximately one hour.) One of the outcomes of this exercise is the realization that there is no perfect model. The strengths of one approach may be the weaknesses of another. The debate exercise could be followed with a discussion of strategies for minimizing the inherent weaknesses of each model and maximizing its potential benefits. Participants may also brainstorm factors which influence the decision to adopt a given model, such as local resources, existing services, and interagency involvement.

4. The following exercise will give participants an opportunity to analyze how service coordination is being implemented in local programs. Ask participants to consider an early intervention setting, such as their practicum site, with which they are familiar. In small groups, ask participants to consider the following questions.

   a. What are the various ways in which parents are involved in service coordination in this setting?

   b. What are the responsibilities of the service coordinator?

   c. How does the service coordinator facilitate families' transitions among services?

   d. What preparation/training do service coordinators get for their roles?

   e. What procedures exist for handling differences among parents and professionals?

f. How do agency policies facilitate or impede effective parent/professional collaboration?

g. How do agency policities facilitate or impede effective interprofessional collaboration?

h. How is the service coordination program funded?

After about fifteen minutes, facilitate a discussion in the large group of the ways in which different agencies have addressed these issues.

SECTION III:

Evaluation

Evaluation Results

How to measure the effectiveness of training in the area of working with families is a timely and challenging question. Traditionally preservice training has been evaluated through participant knowledge tests and participant satisfaction measures. However, this approach has been described as inadequate within the early childhood literature and current emphasis has been placed on the importance of addressing student outcome at the levels of knowledge, attitudes and skills (McCollum, 1982). The problem this poses for those attempting to evaluate family curricula is twofold in that the field is still working towards 1) identifying an agreed upon set of family competencies, and 2) developing valid and reliable instruments and strategies for measuring those competencies. One of the ongoing activities of the Carolina Institute for Research in Infant Personnel Preparation has been the development and field-testing of measures for assessing the efficacy of training in family-centered content. The preservice families course has provided one context for this activity, and the evaluation results which follow include a portion of the efforts in this area of study.

As mentioned earlier, the student competencies addressed in the families curriculum are at the knowledge and attitude levels. Therefore, a knowledge test and two attitude measures, one related to working with families and one related to working with teams, were used for evaluation purposes, in addition to a student satisfaction measure. These instruments are all provided in this section of the curriculum.

Knowledge Test. A 31 item knowledge test, consisting of true-false, multiple choice and short answer questions was administered to students at the end of the course. The total possible score was 31. The mean score was 30, the range being from 25 to 31. This suggested that all students exited the course with an acceptable level of factual information about working with families.

Issues in Early Intervention. (Humphry & Geissinger, 1990). An experimental measure of attitudes towards working with families in early intervention, developed through Institute efforts, was used to collect pre/post data on students. There was a significant difference ($p<.0001$) in the expected direction between the mean pre and post scores on this measure. Although precautions should be taken in interpretations of this result because of the experimental nature of this measure, this suggested that students' attitudes towards working with families became more family-centered over the semester, possibly as a result of the families curriculum.

The Interdisciplinary Team in Early Intervention. (McWilliam, 1990). An experimental measure of attitudes towards working on teams in early intervention, developed through Institute efforts, was used to collect pre/post data on students.

There was a significant difference (p<.0001) in the expected direction between the mean pre and post scores on this measure. Again, precautions in interpretations must be made because of the lack of data on reliability and validity of this instrument; however it does suggest that students' attitudes towards working with teams changed as a result of the interdisciplinary course experience.

Participant Feedback. A measure of student satisfaction was administered at three points in time over the semester: 1 month, 2 months, and 3 months into the semester. At each data collection point satisfaction was quite high. With a rating of "5" indicating the highest level of satisfaction, the mean scores were X=4.1 at Time 1, X=4.1 at Time 2 and X=4.1 at Time 3. In response to the open-ended question, "What aspect of the class was most beneficial?", most students mentioned the class discussions and the opportunity to hear the perspectives of participants from different disciplines and backgrounds.

Disciplinary differences in participant outcome. A question of interest related to whether or not there were disciplinary differences in terms of student outcomes. To address this question, students were grouped according to whether their current discipline was within one of the health related schools or divisions (nursing, speech-language pathology, physical therapy) or within the education school (school psychology, special education). Comparisons between these two groups were made on the measures described above. There were no significant differences.

Participant Demographic Information

Preservice Families Project

Today's Date ____/____/____
MM DD YY

Please circle the appropriate number or letter corresponding to your answer for each item or else supply the requested information.

1. Please provide the last four digits of you social security number.

   __ __ __ __

2. Your name

   ____________________, ____________________
   (Last) (First)

3. Sex
   - ☐ Female
   - ☐ Male

4. Birthday ____/____/____
   MM DD YY

5. Race
   - ☐ American Indian
   - ☐ Asian
   - ☐ Black
   - ☐ Hispanic
   - ☐ White
   - ☐ Other (specify ________________)

6. Marital Status
   - ☐ Married
   - ☐ Not married

7. Parental Status
   - ☐ No children
   - ☐ Have children

8. Please indicate the highest degree(s) you have earned and place the appropriate discipline code(s) in the space following the degree.

	Discipline	**Code**
☐ Associate	______________,	________
☐ Bachelors	______________,	________
☐ Masters	______________,	________
☐ Doctorate	______________,	________
☐ Medical Doctor	______________,	________

Discipline codes:

01 Audiology
02 Education
03 Medicine
04 Music Therapy
05 Nursing
06 Nutrition
07 Occupational Therapy
08 Physical Education
09 Physical Therapy
10 Psychology
11 Rehabilitation
12 Social Work
13 Special Education
14 Speech/Language Pathology
15 Other (specify)________

9. Please indicate the degree you are currently seeking and place the appropriate discipline code in the space following the degree.

	Discipline	**Code**
☐ Associate	______________,	________
☐ Bachelors	______________,	________
☐ Masters	______________,	________
☐ Doctorate	______________,	________
☐ Medical Doctor	______________,	________

10. In which year of your graduate program or residency/internship are you?

_____

11. Have you taken courses in the area of the family or been exposed to family content in courses where the primary focus was not the family?

yes no

If yes,

a. Number of courses in the area of the family _____

b. Number of courses where some family content was provided but was not the primary focus _____

12. Have you taken courses in the area of early childhood or been exposed to early childhood content in courses where the primary focus was not the young child?

yes no

If yes,

a. Number of courses in the area of early childhood _____

b. Number of courses where some early childhood content was provided but was not the primary focus _____

13. Please indicate how many years of professional work experience you have had. ______

Please list the types of professional work you have done:

	Occupation	**Length of Employment**	**Hrs. Worked/Week**
a.			
b.			
c.			

14. How many years have you worked with handicapped children and their families? ______

15. Please briefly describe any practica/internship experiences you have had related to families or young children (ages 0 to 5).

	Type of Setting	**Population Served**	**Length of Time**	**Hrs. Worked/Week**
a.				
b.				
c.				

16. Following completion of your present degree, what type of work would you like to do (e.g., type of setting, population served)?

____

____

____

____

____

(Garner-McGraw, McWilliam & Winton, 1990)

ID # ___ ___ ___ ___
(last 4 digits of SS #)
DATE:___/___/___

Knowledge Test
Working with Families in Early Intervention:
An Interdisciplinary Perspective

These questions are based on the objectives and readings you did for this course. Please respond to each question to the best of your ability. With the exception of short answer questions, please circle your response to each question. Thank you.

1. The mandates of P.L. 99-457 are the same for Part H (birth to 3 years) and Part B (3 to 5 Years). **T** **F**

2. North Carolina has passed state legislation mandating the early intervention services to children and families guaranteed by P.L. 99-457. **T** **F**

3. P.L. 99-457 mandates that an Individualized Family Service Plan (IFSP) must be developed for each child eligible for intervention services, both at the 0-3 age range and the 3-5 age range. **T** **F**

4. Please list and briefly describe three models of disciplinary teaming.
   a. ____
   ____
   b. ____
   ____
   c. ____
   ____

5. Regardless of disciplinary training and background, most professionals working in early intervention settings use the same diagnostic measures and instruments when assessing children. **T** **F**

6. Mr. & Mrs. Sanchez' new baby almost died from a life-threatening illness that left the baby neurologically damaged. When the baby comes home after a lengthy hospital stay, the Sanchez family refuses the help of the early intervention team. They say they hope a miracle will cure their daughter just as a miracle saved her from death. Choose the interpretation of their approach to intervention that would be considered the most family focused: (circle one)

   a. This is an example of denial.
   b. This is a perceptual coping strategy.
   c. This is a family with cognitive deficits.
   d. This family needs a thorough psychiatric assessment.

7. Family values and traditions impact on the day to day routines of the family. **T** **F**

8. An intervention approach that is successful with one family of a given cultural background is quite likely to be successful with other families of that cultural background. **T** **F**

9. The way a family defines a stressor event will influence their adaptation to that event. **T** **F**

10. Research has indicated that intervention services provide the greatest source of support to families of young children with handicaps. **T** **F**

11. Basically all families of children with handicaps adapt to the stressors associated with parenting a child with handicaps in the same way. **T** **F**

12. An interventionist told a mother of a young handicapped child that the mother would have to spend 20 minutes a day doing physical therapy exercises with her child. This is an example of family empowerment. **T** **F**

13. Parents of young children with handicaps who are mentally retarded themselves should be excluded from the empowering approach to intervention described by Dunst, Trivette, & Deal (1988). **T** **F**

14. P.L. 99-457 states that family members are a part of the multidisciplinary team. T F

15. An infant or toddler (under three years) cannot receive any early intervention services until an IFSP has been completed and placed in the child's file. T F

16. Regardless of the child's level or type of disability, families have the right **not** to enroll the child in an early intervention program. T F

17. Professional perspectives on the needs of young children with handicaps lead to more functional goals being set than do parental perspectives. T F

18. Child assessment should be shaped by the following: (circle one)
    a. family priorities
    b. informational needs of family
    c. child characteristics
    d. professional concerns
    e. all of the above

19. Informed consent must be obtained from parents for any and all assessment activities. T F

20. Part H of Public Law 99-457 and the proposed regulations do not prescribe particular assessment formats or procedures. T F

21. An interventionist determined from demographic information that a child's grandmother lived next door to the child's family. The interventionist identified the grandmother as a 'family strength' on the IFSP document. In a sentence please critique this approach.

    ____
    ____
    ____

22. You are an administrator reviewing IFSP's. You review one that has only goals in which the child is the target. Can this IFSP be considered appropriate given P.L. 99-457? (Choose one answer and please give a brief rationale for you choice).
    a. yes (Rationale: ________________________________)
    b. no (Rationale:________________________________)
    c. cannot be determined from this information (Rationale:
    ____)

23. P.L. 99-457 has mandated that IFSPs must include a statement of outcomes including the criteria, procedures and timelines used to determine progress towards achieving them. T F

24. P.L. 99-457 states that professional decisions regarding IFSP outcomes should override parental decisions when there is team consensus that the parents' decisions are not in the best interest of the child. T F

25. The intent of P.L. 99-457 is for all states and communities to use a standard IFSP format. T F

26. Research has documented that communication is an art; communication skills cannot be taught. T F

27. Research has demonstrated that communication is primarily a verbal activity. T F

28. Closed-ended questions are the most effective way of gathering information from families because they provide more specific information. T F

29. In P.L. 99-457, it is stated which discipline should be responsible for carrying out the case manager's role in early intervention. T F

30. Providing information and making referrals are considered to be the most important roles for a case manager. T F

31. P.L. 99-457 states that a professional who feels best qualified to be the case manager can designate themselves to function in that role with an individual family. T F

ID # ___ ___ ___ ___
(last 4 digits of SS #)
DATE:___/___/___

Participant Satisfaction

Working with Families in Early Intervention:

An Interdisciplinary Perspective

Please answer the following questions by circling the response which best represents your own opinion. If you have additional comments you would like to make, write them in the margins or on the back of the last page. Please be honest in providing this feedback as it will be used in making revisions in the course curriculum.

1. How useful were the topics covered by the course (as outlined in the course syllabus) in preparing students to work with families?	1 Not very	2	3 Somewhat	4	5 Very
2. How useful were the assigned readings?	1 Not at all	2	3 Somewhat	4	5 Very
3. How much time did it take to complete assigned readings?	1 Very little	2	3 A reasonable amount	4	5 Too much
4. How much time did it take to complete homework assignments or prepare for case discussion?	1 Very little	2	3 A reasonable amount	4	5 Too much
5. How useful was the information or guidance provided by the instructor during class?	1 Not at all	2	3 Somewhat	4	5 Very
6. How useful were the class discussions?	1 Not at all	2	3 Somewhat	4	5 Very
7. How useful were the contributions to discussions made by other students?	1 Not at all	2	3 Somewhat	4	5 Very
8. How comfortable did you feel participating in class discussions?	1 Not at all	2	3 Somewhat	4	5 Very

9.	How useful were the case examples or case studies provided by the instructor in understanding the course content?	1 Not at all	2	3 Somewhat	4	5 Very
10.	How useful has it been to have students from different disciplines together in the same class?	1 Not at all	2	3 Somewhat	4	5 Very
11.	How well prepared would a student taking this class be to work with families of very young children with handicaps?	1 Not at all	2	3 Somewhat	4	5 Very
12.	How useful was the individual (videotaped) role-play to you as a learning experience in working with families?	1 Not at all	2	3 Somewhat	4	5 Very
13.	How useful do you think the information and experiences from this class related to working with professionals from other disciplines **(interdisciplinary/teamwork)** will be in your future professional work?	1 Not at all	2	3 Somewhat	4	5 Very
14.	How useful do you think the information and experiences from class related to **working with families** will be in your future professional work?	1 Not at all	2	3 Somewhat	4	5 Very
15.	How similar were the ideas and information presented in class on working with families to those you have encountered in other classes or through practicum/internship placements?	1 Not at all	2	3 Somewhat	4	5 Very
16.	Would you recommend this class to other students in your departmental training program?	1 Definitely not	2	3 Uncertain	4	5 Definitely

17. How interested would you be in taking additional course work on working with families (follow-up to this course)?	1 Not at all	2	3 Somewhat	4	5 Very

If interested, what content would you like to see included in follow-up course work?

18. How interested are you in pursuing a career in early intervention?	1 Not at all	2	3 Somewhat	4	5 Very

19. What aspect(s) of this course have you found to be most beneficial to you? (Use back of page if necessary).

20. What changes, if any, do you think need to be made in conducting this course? (Use back of page if necessary).

(McWilliam, P. J., 1990)

Issues in Early Intervention

We would like you to share your opinions about issues in early intervention. Please circle the response which best reflects your opinion.

SA = Strongly Agree
A = Agree
U = Uncertain
D = Disagree
SD = Strongly Disagree

1.	I have some concern about whether the early intervention legislation (P.L. 99-457) will actually work for the benefit of children with special needs.	SA	A	U	D	SD
2.	Interventionists are more likely to be realistic about a child with special needs than are the parents.	SA	A	U	D	SD
3.	I believe it is OK for a family to take a break from therapy even if I think that the child's progress may suffer.	SA	A	U	D	SD
4.	Parents are as capable as interventionists in identifying needs of their child.	SA	A	U	D	SD
5.	The most appropriate time to include families in setting priorities for treatment is in the post assessment period when we know something about the child's abilities.	SA	A	U	D	SD
6.	To be the most effective, therapy needs to occur with a caregiver in the room.	SA	A	U	D	SD
7.	Families should help determine the nature of the assessment.	SA	A	U	D	SD
8.	Information about available services should be provided to parents before establishing goals.	SA	A	U	D	SD
9.	Interventionists should focus their attention on teaching mothers information about caring for their children.	SA	A	U	D	SD
10.	If a family does not follow through on recommended activities, the interventionist should explain their importance and make suggestions that would help them follow the recommendations.	SA	A	U	D	SD
11.	In setting priorities, the interventionist should adhere to what s/he thinks is best for the child even if the family requests alternative priorities.	SA	A	U	D	SD

12. During the first few months after a family learns of their child's disability, it is not realistic to expect them to be involved in planning services. SA A U D SD

13. Families do not have adequate information to deal with setting goals until they hear about evaluation results. SA A U D SD

14. Using parent input for setting goals might compromise the quality of intervention services. SA A U D SD

15. It is hard for families to be realistic about the infant's abilities when s/he has developmental delays. SA A U D SD

16. Parents are in the best position to decide which disciplines should provide services for their child's needs. SA A U D SD

17. Parents need help to communicate effectively with their child who has special needs. SA A U D SD

18. The child's treatment needs should be identified before asking the parent's priorities. SA A U D SD

19. Families have difficulty knowing what goals are important until they are informed about an agency's services. SA A U D SD

20. My experiences as a family member help me appreciate how other families function. SA A U D SD

21. In setting priorities the interventionist should act as the child's advocate and be sure the parents understand the interventionist's reasons for prioritizing goals as s/he has. SA A U D SD

22. Family involvement in goal setting is not realistic during the first few months after the family learns about their child"s handicap. SA A U D SD

23. Families need professional input to be realistic about the abilities of their child with special needs. SA A U D SD

24. When attendance is a problem the first thing an interventionist should stress is the importance of early treatment. SA A U D SD

(Humphry, R., & Geissinger, S., 1990)

ID # ___ ___ ___ ___
(last 4 digits of SS #)
DATE:___/___/___

The Interdisciplinary Team in Early Intervention

Assessment and intervention services for handicapped infants and their families are typically provided by an interdisciplinary team. Team members represent a variety of professional disciplines (e.g., special education, speech and language pathology, social work, nursing, occupational therapy, nutrition, psychology, physical therapy, audiology, pediatrics/medicine). Each member of the team contributes his or her discipline-specific knowledge and skills in providing early intervention services. Interdisciplinary teams vary in their composition; usually ranging from three to seven members. In addition, team members may work within the same building or may be dispersed across several locations or agencies. Finally, early intervention teams may differ in terms of the population they serve (e.g., type or severity of handicap of children) or the primary function of their services (e.g., assessment, intervention, home-based, classroom-based).

Part I. Instructions: Listed below are 29 statements about interdisciplinary teams in general. Please indicate the degree to which you agree or disagree with each statement using the code provided below. Please provide a response to each statement and only circle one code per statement.

SD= Strongly Disagree
D= Disagree
U= Neither Agree nor Disagree
A= Agree
SA= Strongly Agree

1. Each team member should be fully aware of the assessment and intervention activities conducted by other team members with a child and family.	SD	D	U	A	SA
2. When conflicts arise among team members, it is best to ignore them.	SD	D	U	A	SA
3. Professionals can learn a great deal from team members outside of their own discipline.	SD	D	U	A	SA
4. Involvement of all team members in planning and decision-making is an inefficient use of professional time.	SD	D	U	A	SA
5. The needs of the team should determine the role a professional takes; not the professional discipline of that team member.	SD	D	U	A	SA
6. Some professional disciplines have more to contribute to the early intervention team than others.	SD	D	U	A	SA

SD= Strongly Disagree
D= Disagree
U= Neither Agree nor Disagree
A= Agree
SA= Strongly Agree

7. Professionals should actively encourage other team members to give feedback on the assessment and intervention plans they develop for a child and family before decisions are made. SD D U A SA

8. Frequent communication among team members is not necessary for providing good services to a child and family. SD D U A SA

9. Professionals should share new knowledge and skills (e.g., from journals or workshops) with other members of the team. SD D U A SA

10. Team members should not be involved in decisions regarding child or family issues for which they did not receive specific professional training. SD D U A SA

11. The role of a professional may change considerably when assigned to a different team. SD D U A SA

12. The suggestions of some team members are more important than those of others. SD D U A SA

13. All team members should hold a common belief or philosophy about the goals of services to children and families. SD D U A SA

14. When developing an intervention plan for a child or family, asking the opinions of team members outside your own discipline is an effective use of everyone's time. SD D U A SA

15. Professionals should share their discipline-specific skills and knowledge with other team members. SD D U A SA

16. The role of each team member should be clearly defined and consistent over time. SD D U A SA

17. Getting to know other team members on a personal basis is helpful to the smooth operation of the team. SD D U A SA

18. Professionals should concentrate on acquiring new skills and knowledge within their own discipline and not cross over into others. SD D U A SA

19. Decisions or plans arrived at through team consensus are superior to those arrived at by individual team members. SD D U A SA

20. The professional discipline of a team member should define his or her role on the team. SD D U A SA

SD= Strongly Disagree
D= Disagree
U= Neither Agree nor Disagree
A= Agree
SA= Strongly Agree

21. Professionals are responsible for providing support and encouragement to other team members. SD D U A SA

22. Professionals do not need the input or approval of other team members in planning assessments or interventions related to their own discipline. SD D U A SA

23. Each team member should have as much decision-making power as any other member. SD D U A SA

24. Discussions of team members' feelings about how well the group is working together are a waste of time. SD D U A SA

25. It is important for all team members to express their opinions before a final decision is made. SD D U A SA

26. Professionals should ensure that skills related to their discipline are not used by team members trained in other disciplines. SD D U A SA

27. The contributions of all professional disciplines on a team should carry equal weight. SD D U A SA

28. Team members should restrict their activities with children and families to those related to their discipline-specific professional training. SD D U A SA

29. Team members need to like each other in order to be able to work together effectively. SD D U A SA

Part II. Instructions: Suppose you are developing an early intervention program for handicapped infants and their families. The program is designed to provide both assessment and home-based intervention services. Using the list below, indicate your priorities for the staffing of your new program. Put a "1" beside the professional discipline you think is most necessary for the program (i.e., early intervention team). Place a "2" beside the discipline which is the next most important, and so on until you have ranked all ten disciplines according to your own priorities.

____ Special Education
____ Speech and Language Pathology
____ Occupational Therapy
____ Nursing
____ Nutrition
____ Psychology
____ Social Work
____ Pediatrics/Medicine
____ Audiology
____ Physical Therapy

(McWilliam, P.J.,1990)

SECTION IV:

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SECTION V:

Appendices

Appendix A

Outline of Core Competencies for Working with Families in Early Intervention

Five major functions performed across disciplines are identified and separated into general competencies. Specific conceptual (knowledge), perceptual (attitude) and behavioral (practice) skills are described in the form of instructional objectives and are listed under each competency.

These competencies were derived from the following sources:

1. Current literature (Bailey & Simeonsson, 1988; Dunst, Trivette & Deal, 1988; Johnson, McGonigel, & Kaufman, 1989; Turnbull & Turnbull, 1986) defining "best practice" in working with families in early intervention.

2. A prioritization of content areas for inclusion in the preservice families curriculum by faculty and students who pilot-tested the curriculum on the UNC campus.

3. An inservice curriculum on family-focused intervention pilot-tested in North Carolina, Maine and Louisiana.

Major Functions and Related Competencies

I. Developing a Philosophical Framework
   - A. Incorporating an ecological approach
   - B. Incorporating a family systems approach
   - C. Incorporating an empowering approach

II. Collaborating with Other Professionals
   - A. Incorporating an interdisciplinary approach to intervention
   - B. Establishing a collaborative relationship with professional team members

III. Gathering Family Information
   - A. Developing an assessment plan
   - B. Identifying families' resources, priorities and concerns

IV. Planning Intervention with Families
   - A. Identifying families' aspirations, hopes and outcomes
   - B. Identifying alternative strategies and criteria for accomplishing outcomes
   - C. Working as part of team in developing a written plan which integrates assessment and goal-setting information (IFSP)

V. Implementation
   - A. Providing, monitoring and evaluating direct services identified in IFSP
   - B. Coordinating with other professionals or agencies who might provide services as needed
   - C. Mobilizing existing social supports as needed

Specific Skills Related to Competencies

I. Developing a Philosophical Framework

A. Incorporating an ecological approach

1. Conceptual
    - a. Demonstrate knowledge of an ecosystemic paradigm as a way of understanding "at risk" children, families and the role of early intervention
    - b. Describe the mandates and intent of P.L. 99-457 and related legislation in regard to parental rights and responsibilities related to early intervention
2. Perceptual
    - a. Espouse the belief that families should be able to participate as equal partners in the planning of goals and services
3. Behavioral
    - a. Demonstrate the ability to individualize working with families, depending upon each family's unique situation.
    - b. Demonstrate strategies that allow families to exercise their legal rights of equal partnership, if they want

B. Incorporating a family systems approach

1. Conceptual
    - a. Demonstrate knowledge of three key components of family systems theory (subsystems, boundaries and hierarchies) and their implications for intervention with families
    - b. Describe one's own cultural values and how these might affect your work with families
2. Perceptual
    - a. Espouse the attitude or belief that the young child is best understood in the context of the whole family, and that change or intervention directed at one family member affects every other member
    - b. Recognize that every family has strengths, resources, and capabilities
3. Behavioral
    - a. Make efforts to bring the whole family together and explain the rationale for eliciting the support of all relevant family members in the intervention process
    - b. Demonstrate the ability to adapt intervention practices to fit the cultural context of different families

C. Incorporating an empowering approach

1. Conceptual
    - a. Define "needs-based" and "service-based" approaches to intervention and explain the differences between the two
2. Perceptual
    - a. Espouse the attitude or belief that effective intervention begins with how families define their situation rather than with a presentation of services available
3. Behavioral
    - a. Demonstrate the ability to listen to how families define their situation and the events related to their handicapped child.

II. Collaborating with Other Professionals

A. Incorporating an interdisciplinary approach to intervention

1. Conceptual

        a. Describe briefly the major roles in early intervention of the following disciplines: nursing, physical therapy, occupational therapy, speech, pediatrics, audiology, nutrition, special education, psychology
        b. Describe mandates and intent of P.L. 99-457 and subsequent state laws as they affect interagency collaboration at the state and local levels
    2. Perceptual
        a. Espouse the belief that early intervention is not the work of a single discipline but must be conducted in an interdisciplinary context in order to be effective
        b. Recognize that service delivery systems are often fragmented and uncoordinated; creating ways to coordinate services at local, regional and state levels will improve services for children and families
    3. Behavioral
        a. Demonstrate the ability to seek out specialized knowledge and act as a resource in coordinating with other professionals, as needed, in developing and implementing an intervention plan according to family preference
        b. Identify and meet with professionals from all agencies and programs in your local community relevant to early intervention to identify key issues associated with coordinating services and to develop a plan for addressing those issues

B. Establishing a collaborative relationship with professional team members
    1. Conceptual
        a. Describe the dimensions of effective teams and the dynamics of team interaction, including decision-making, communication and conflict resolution
    2. Perceptual
        a. Espouse the belief that one's own leadership and membership styles affect team dynamics
    3. Behavioral
        a. Analyze your role and the roles of others who are members of a team; develop a plan with other team members focusing on how the team could become more effective

III. Gathering Family Information

A. Developing an assessment plan
    1. Conceptual
        a. Describe a strategy for involving families in the development of an assessment plan
    2. Perceptual
        a. Espouse the belief that families should be able to determine the level and extent of their involvement in planning assessments
    3. Behavioral
        a. Demonstrate the ability to determine the following in collaboration with the family: the family's role in assessment, the context for assessment, the major target areas for assessment, and who will be involved in the assessment

B. Identifying families' resources, priorities and concerns
    1. Conceptual
        a. Identify at least two strategies or means of identifying family resources, priorities and concerns
        b. Provide a definition of family "strengths" that is "free" of cultural and ethnic bias
    2. Perceptual

    - a. Espouse the belief that intervention efforts should start with the family's definition of what is important
    - b. Recognize that personal values and biases affect definitions of strengths
  - 3. Behavioral
    - a. Demonstrate the effective identification of family needs, perspectives and strengths and link that information with child and family outcomes in developing an intervention plan
    - b. Demonstrate the ability to accept the way a family defines events without making judgments and providing unsolicited advice

IV. Planning Intervention with Families

A. Identifying families' aspirations, hopes and outcomes

- 1. Conceptual
  - a. Demonstrate knowledge of the issues associated with collaboratively establishing outcomes with families
  - b. Identify questioning skills related to effectively generating family outcomes, alternative strategies for achieving outcomes and criteria for success
- 2. Perceptual
  - a. Espouse the belief that early intervention outcomes generated by families are more likely to be effectively achieved by families than outcomes generated by professionals
  - b. Espouse the belief that all families, regardless of cultural or SES background, have resources which might be effective in achieving outcomes and that the use of certain questioning skills is an effective strategy for identifying family outcomes
- 3. Behavioral
  - a. Engage families in the process of collaboratively generating a set of intervention outcomes
  - b. Demonstrate the use of questioning skills in order to collaboratively generate a set of intervention outcomes

B. Identifying alternative strategies and criteria for accomplishing outcomes

- 1. Conceptual
  - a. Demonstrate knowledge of the range of community services and resources related to families and young handicapped children and the variety of ways services are financed
- 2. Perceptual
  - a. Recognize the importance of providing families with unbiased, clear, and practical information about the availability, accessibility and affordability of agencies and resources that match their needs and might help them achieve identified outcomes
- 3. Behavioral
  - a. Provide families with information about community services that match identified needs, when existing resources are deemed inadequate, and might provide acceptable alternatives for achieving outcomes

C. Working as part of team in developing a written plan which integrates assessment and goal-setting information (IFSP)

- 1. Conceptual
  - a. Demonstrate knowledge of the key components of the IFSP process and a format for writing an IFSP that meets the criteria set forth in P.L 99-457

   - b. Demonstrate knowledge of the criteria for IFSP review and reassessment
  - 2. Perceptual
    - a. Recognize that the process of generating an IFSP document is more important than the written document; therefore, there are a variety of formats which might be acceptable
    - b. Recognize that the IFSP is a "living document", which will be continually revised as needs and outcomes become clarified, revised and or made more evident over time
  - 3. Behavioral
    - a. Develop and write an IFSP in collaboration with a family
    - b. Revise an IFSP in collaboration with a family

V. Implementation

A. Providing, monitoring & evaluating direct services identified in IFSP

- 1. Conceptual
  - a. Demonstrate knowledge of the basic competencies associated with your discipline and the related services that might be provided to young children with disabilities and their families and strategies for monitoring effectiveness in terms of achieving outcomes
- 2. Perceptual
  - a. Recognize the importance of providing services according to "best practice" definitions of your discipline and monitoring the effectiveness of direct services provided
- 3. Behavioral
  - a. Provide direct services as identified in IFSP and conduct a review of progress with the family at least every 90 days

B. Coordinating with other professionals or agencies who might provide services as needed

- 1. Conceptual
  - a. Demonstrate knowledge of the basic competencies associated with models of service coordination
- 2. Perceptual
  - a. Recognize the importance of assisting families in the process of linking themselves and their children with service providers and coordinating services
- 3. Behavioral
  - a. Demonstrate the ability to help families link themselves with services identified in the IFSP and coordinating those services

C. Mobilizing existing social supports as needed

- 1. Conceptual
  - a. Demonstrate knowledge of a social systems approach to intervention in which family independence vs. dependence on professionals is promoted
- 2. Perceptual
  - a. Recognize the importance of using existing support systems in achieving outcomes whenever possible as a means of promoting competence and independence in families
- 3. Behavioral
  - a. Help family members to mobilize external resources and to influence them to be constructive

Vignette—The Mack Family

Lita was born at 28 weeks gestation to Mark and Dee Mack. Lita was the Macks' second child. Her older brother, Jeremy, was two years old when she was born. The Macks' live in south central Wisconsin in a rural community about forty minutes from the medical center where Lita was born.

Lita's early life was spent in an isolette in the NICU. Lita was diagnosed as having Bronchopulmonary Dysplasia and a small ventricular septal defect. She spent four months in the hospital and was discharged while she was still on oxygen and an apnea monitor and still fed with a naso-gastric tube. Shortly after Lita was discharged, she was referred to the Linking Infants and Families Together (LIFT) project and was seen by an infant specialist.

One of the Macks' major concerns was Lita's inability to sustain nourishment. Her feeding problems and frequent vomiting bouts resulted in very poor growth. Lita was frequently hospitalized–trips to the medical center became an almost weekly routine. Dee was left with no time alone and little time to spend with Jeremy.

The Macks were fortunate to have Project LIFT, an early intervention program, in their community.

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Appendix C

The Crowder Family

Theresa and Michael Crowder and their three children, Julie, 16; Roger, 7; and Mary, 21 months, live in metropolitan Boston. Mrs. Crowder has AIDS Related Complex (ARC) and her youngest child, Mary, who was HIV positive at birth, has recently been diagnosed with ARC as well. Mrs. Crowder and her husband are separated, and Mrs. Crowder receives AFCD. Mrs. Crowder, Julie, and Mary live in a large subsidized apartment complex.

Mrs. Crowder and her sister Yvonne are very close, and Yvonne is a strong and consistent support to Mrs. Crowder and her children. As Mrs. Crowder's disease has progressed, Yvonne has helped out by having Roger live with her family. Yvonne and her husband run a small grocery store in a nearby neighborhood. They have a son a year older than Roger, and the boys are good friends. Whenever Mrs. Crowder is hospitalized for ARC treatment, Yvonne also cares for Julie and Mary in her home.

Mrs. and Mr. Crowder have lived separately for the last year. Theresa is struggling to control her drug addiction. Because Mr. Crowder is an active drug user, Mrs. Crowder wants to live apart from him. She has entered Methadone treatment programs several times in the past two years.

Mrs. Crowder and Yvonne come from a large Italian family. Their parents are dead, but they have four brothers who live in the "little Italy" section of the city where Yvonne and her family live. These brothers operate a thriving olive oil import business. Yvonne has remained close to her brothers, but Theresa Crowder has been estranged from them for many years. Theresa was always the "rebel" of the family. She was the only one of her siblings who went to college, although she only attended for one year on a music scholarship. It was there that she met Mr. Crowder. When she married Mr. Crowder, who is not Catholic or Italian, her relationship with her family, except for Yvonne, was severed. In fact, her brothers still say "Mama" died of a broken heart over what became of Theresa.

Yvonne has been very supportive of Mrs. Crowder's efforts to manage her addiction, but Yvonne becomes angry with her sister when she quits treatment. Yvonne, who has very strong religious beliefs, is impatient of Mrs. Crowder's drug dependence. Because she counts on Yvonne for support, Mrs. Crowder has recently promised her sister to recommit to a treatment program. She knows it will be a struggle, but her relationship with Yvonne is very important to her.

Mrs. Crowder's health has begun to fail in the past six months. She battles minor infections and bouts of overwhelming fatigue. Because of her own physical needs, Mrs. Crowder often feels overwhelmed by the demands of her toddler, Mary.

Julie has always been a big help to Mrs. Crowder in taking care of Mary. However, she is starting to have problems of her own now. Always a good student, her last report card was terrible. She seems glum and moody at home and is spending more time elsewhere. Mrs. Crowder had always hoped Julie could go to college on a scholarship, but now she is worried that Julie's last report card will ruin her chances.

Although Mrs. Crowder is anxious for Mary to be with other children, she lacks the stamina to take her to the playground or to get together with other mothers and children. She is also very concerned about her neighbors discovering that she and Mary are HIV positive. Mrs. Crowder is very guarded about this medical information and has told no one outside her immediate family. Although she feels very alone, she is frightened of people learning about her disease.

Mary's health is poor. She has chronic diarrhea and recurrent ear infections. Mrs. Crowder says Mary is irritable and hard to comfort. Mary is also quite small for her age, and Mrs. Crowder worries about her daughter's ability to fight infection. Mrs. Crowder mentions mealtimes as particularly stressful for the family. Mary is a fussy eater, often refusing what is offered, and throwing her food on the floor. Mrs. Crowder says that she sometimes feels angry at the baby for making such a mess. Usually, though, she just feels tired at the thought of cleaning it up and is anxious for Mary to become a better eater and get stronger.

[Adapted with permission of NEC*TAS and ACCH from Johnson, B., McGonigel, M., & Kaufman, R. (Eds.). (1991). *Guidelines and recommended practices for the individualized family service plan* (2nd ed.) (p. 20). Bethesda, MD: Association for the Care of Children's Health.]

Case Vignette Activity

1. Diagram the Crowder family's internal and external structure using a genogram and ecomap.

2. In making this diagram, did you feel there is additional information about this family's structure that you would want to collect in order to plan intervention? If yes, please describe what this information is.

3. List three concepts related to family systems theory which you think would be relevant to consider if you were working with this family in an intervention situation. Describe these concepts and give a brief rationale for why you think they are relevant.

4. Describe in writing what strategies you would use to collect information related to these concepts and give a brief rationale for why you selected these strategies.

Appendix D

Reflecting Feelings Exercise

#1

M: I try, honestly, to do the physical therapy exercises, but I don't get anywhere. Working hard doesn't seem to make any difference; he's still so far behind.

I: I guess you're depressed.
[Instructor's Note–Don't overinterpret]

I: You sound frustrated.

#2

M: What can I do? I don't know anything about babies with problems. I know I should do something, but I don't know what.

I: You sound as if you've given up all hope.
[Instructor's Note–By saying she should do something, Mother has indicated that she hasn't given up all hope . . . she's confused]

I: It's hard to know which way to turn.

#3

M: (Showing interviewer a snapshot of her son) You should have seen him at his party. He was really something . . . sitting up like a big boy with all of the other children.

I: That's cute. But don't get your hopes up. You know he's not always going to be able to participate with normal kids.
[Instructor's Note–This is advice.]

I: That's cute. You really enjoyed seeing him have so much fun.

#4

M: (Mother has her head down, speaking in a low tone of voice) I was going out of town, but now my mother-in-law is coming for the weekend.

I: (looking for some papers in her lap) It sounds as if that will be just as enjoyable.
*[Instructor's Note–Not only attend to **what** is said, but **how** it is said.]*

I: You don't look too happy about that.

#5

M: Jesse is going to be evaluated at the clinic next week. I'm eager to find out more about his condition, but I know it's going to be a long, hard day.

I: It's really going to be great to get more information about Jesse.
[Instructor's Note–Important to reflect both messages conveyed in a mixed message. Also to try and better understand exactly the nature of her concerns reflect in question form.]

I: You're looking forward to getting more information, but you're anxious about the long evaluation process?

#6

M: (Said with tears in her eyes) I'm really glad Jason has gotten into the developmental center

I: (looking briefly at her notes) Oh, I know you're happy about that.
[Instructor's Note–Note verbal and nonverbal behavior.]

I: You say you're glad, but you look kind of sad too.

#7

M: (Fidgeting, looking anxious, biting nails, etc. and not talking)

I: Surely, it can't be that difficult to talk about this; I can't help you unless you talk.
[Instructor's Note–Important to use silence to encourage discussion of difficult issues and respect someone's discomfort in continuing.]

I: (Silence) You seem uncomfortable going on with this discussion?

Appendix E

Scripted Roleplay of Questioning Skills

Linear Questioning

Interventionist: What needs do you have as a family?

Father We need help getting Johnny to eat right.

Interventionist: Who feeds Johnny?

Father: My wife.

Interventionist: What kinds of problems do you have with feedings?

Mother: Getting him to feed himself.

Interventionist: Are you using foods that he can easily pick up?

Mother: Yes.

Interventionist: Have you had this problem evaluated?

Mother: Evaluated? Well, I've talked to the pediatrician. he said Johnny is gaining weight so it wasn't that serious. Anyway he set up an appointment with a nutritionist who works at his office. She told me some things to try, but none of them seemed to work.

Interventionist: Why do you think they didn't work?

Mother: I don't know.

Circular Questioning

Interventionist: How are things going at home right now with Johnny?

Father: Pretty well . . . we have our ups and downs. Right now a big problem is getting him fed.

Interventionist: Could you tell me a little bit about what feeding him is like?

Father: Well, it's a mess. We're trying to get him to feed himself, but that's not working. And when she feeds him, she can't tell what's going in.

Interventionist: Sounds difficult *(to the mother)* . . . who all has been involved in feeding Johnny?

Mother: Just me really. He's *(nodding towards Dad)* given up . . . says he can't do it.

Interventionist: *(To Dad)* What happens when you've tried?

Father: She usually starts telling me what I'm doing wrong, and she's right. I can't get anywhere with him.

Interventionist: How do you react to that?

Father: Well, I just turn it over to her . . .

Mother: You mean you just leave . . .

Father: Well, it all gets so chaotic, I do get the urge to just get out of here.

Interventionist: What else is going on that makes it chaotic?

Mother: The other kids are hungry, and they start asking for snacks and getting into things and that gets me upset.

Interventionist: Have you gotten any advice on this that has been helpful?

Mother: Not really. I've talked to my pediatrician about it and he says it's not a real problem because Johnny is gaining weight. He sent me to a nutritionist. She had lots of advice, but none of it seemed to work *(sounding discouraged)*.

Interventionist: You sound pretty discouraged.

Mother: I am

Interventionist: If things could be different during Johnny's feeding time, what would be the thing that would make the biggest difference?

Mother: Um *(thinking)*–I guess if I had some peace and quiet.

	Strategic Questioning
Interventionist:	Why don't you ask your husband to help?
Mother:	I do, but he says he can't take the yelling.
Interventionist:	*(To Dad)* Could you try and help out . . . maybe you could help with the other kids?
Father:	When I try to help, everything I do is wrong.
Mother:	That's because you just let the kids eat anything they want and it spoils their dinner.
Interventionist:	*(To Mom)* Can you fix the kids a snack earlier so they won't bug you while you're feeding Johnny?
Mother:	They say they're not hungry earlier and don't want anything.
Interventionist:	This sounds like a problem you two need to work on. I could make a referral to our psychologist on our team.

[This example illustrates how ineffective the interventionist is when he/she tried to generate goals, based on what he/she thought ought to happen.]

	Reflexive Questioning
Interventionist:	*(To Mom)* Going back to what you said about wishing there could be some peace and quiet, what is different about the times when there is peace and quiet?
Mother:	Um hum…it has been so long–I guess I can't remember what was different except that Johnny wasn't born.
Interventionist:	What will it take to get some peace and quiet at mealtime now?
Mother:	A miracle and that's not going to happen.
Interventionist:	If things continue like they are now when you're trying to feed Johnny, what do you think might happen?
Mother:	I don't know…I might go crazy…I'm not seeing any improvement in the way things are and it really is getting me down.
Interventionist:	*(To Mom)* If you were to share with him *(nodding to Dad)* how down you are about this situation, what do you think he might think or do?
Mother:	I don't know.
Interventionist:	*(To Dad)* What do you think you might think or do?
Father:	Well, I guess I didn't realize how upset she was . . . I guess I would try to figure out how I could help.
Interventionist:	*(To Dad)* Will that be hard to do?
Father:	Yes, because in the past I've never done it right.
Interventionist:	*(To Mom)* Can you think of ways that he has helped and gotten it right?
Mother:	*(pause)* Um…well, yes… a couple of times on a nice day he has taken the kids outside when he gets home from work. That gives me a chance to concentrate on Johnny without them badgering me. *(Pause)*. If he could help in that way more often, I think it would make a difference.
Interventionist:	What do you think of what she said… how do you think that will work?
Father:	I think it might work, if you kids won't bug me for snacks.
Interventionist:	What do you kids think?

Appendix F

Open-ended Questions to Elicit Information on Family Resources, Priorities and Concerns

Domains of Interest:	Questions:
OPENING QUESTION: Finding out where family wants to focus (addressed to each family member in turn so each has a chance to respond)	"How are things going with Jeremy?"
Understanding family's perspective on child	"What kinds of things does Jeremy enjoy doing?"
Understanding family's definition of child's delay or disability	"What have you been told about Jeremy's (hearing, vision, motor, etc.—using words of family members)?"
	"How does this fit with what you know and believe about Jeremy?"
	"What else do you know about (Jeremy's identified disability)?"
	"In what ways has this information been helpful? or not helpful?"
	"What do you think Jeremy needs help with, if anything?"
	"What kinds of things have you tried that worked? that didn't work?"

Understanding family's informal and formal support system	"What kinds of advice have you been given?"
	"Whose advice has been helpful? not helpful?"
	"What happens in a crisis?" (If crises have been described as happening in the past.)
Understanding family ecology surrounding events of importance to family members	"What is a typical day like?" (or if family has identified a particular event that they want to focus on, asking what a typical mealtime, trip to the park, etc. is like.)
Focusing on solution development	"Can you think of a time that (the event—mealtime, trip to the park, etc.) went well or worked the way you wanted it to? What was happening that made it work?"
	"Who or what was helpful? Who or what was not helpful?"
Understanding critical events that aren't directly related to child	"What other things are going on now that are important to you?"

Appendix G

Open-ended Questions for Generating Family Outcomes

Domains of Interest:	**Questions:**
Understanding family priorities for outcomes	"If you were to focus your energies on one thing for Betsy, what would it be?"
	"If you could change one thing about (event of importance), what would that be?"
Specifying outcomes	"Imagine 6 months down the road, what would you like to be different in terms of (event or area of importance)? Are there some things that you would like to be the same?"
	"What would you like to accomplish in 6 weeks? 6 months?"
Generating solutions or strategies for achieving outcomes that fit family values	"Can you think of a time that (the event—mealtime, trip to the park, etc.) went well or worked the way you wanted it to? What was happening that made it work?"
	"What are some ways of getting to where you want to go?"
	"Who all would need to be involved in getting done what you want to do?"
	"What would each of you need to do in order to accomplish what you want?"

Identifying criteria for success and monitoring progress	"How will you know when you've done what you want to do?"
	"How will you know when Betsy has made progress in the ways you described?"
Setting timelines	"How long do you think it will take to get to where you want to go?"

Family Interview Activity

Preparing for the role play
In your packet, you will find the description of two different families (The Benson Family and The Hatcher Family) told from the perspective of either a parent or a professional. The role play activity has been structured in the following way:

1. You have been divided into small groups of three. Each small group will have the opportunity to participate in three brief role plays, each based on one of the two families. Each participant will have a chance to play all of the following roles: parent, professional and observer.

2. Your role in each of the brief role plays will be determined by the information in your packet. For instance, if you have a description of the Benson family from the perspective of the parent, you would play the role of the parent in the Benson Family role play. If you have a description of the Hatcher family from the perspective of the professional, you would play that role in the Hatcher Family role play. If you have a sheet marked observer for a particular family, that is the role you would play in the third role play.

3. This activity will be videotaped. After the three role plays have been conducted, your small group will have an opportunity to look at the videotape and discuss each role play in turn with the person in the observer role serving as the facilitator for that particular role play. The Family Interview Rating Scale that is included in this packet can be used as a vehicle for self-assessment and feedback.

4. Each brief family role play will take approximately 10 minutes, with additional time needed for viewing the videotape and discussion. The total amount of group time allotted, therefore, should be 1 1/2 hours.

5. To prepare for this activity you should read thoroughly the readings for Module 10 and **should carefully read the information in this packet.** Because you will be playing several different roles, it is important to familiarize yourselves with the family stories **in advance.**

Participating in the role play
Imagine that the meetings described in the family vignettes are taking place. Imagine yourselves in the roles you are playing and try to stay in character with both verbal and nonverbal communications. The observer should remain unobtrusive and observant. The observer has a list of the characters in each vignette. A brief look at this list before the start of the role play may be helpful for everyone. Each role play segment should last about 10 minutes.

Self-assessment and peer feedback
At the end of the three segments, the group should watch the videotape. The Family Interview Rating Scale has been provided with this activity as a mechanism for self-assessment and feedback. A decision about how to use the rating scale needs to be made in advance. Options include:

1. having each person in the group independently rate the interviewer in each vignette using the rating scale and use the ratings as a starting point for discussion;

2. having the person in the role of interviewer rate him/herself and use this information for discussion;

3. use the scales for discussion but do not actually rate anyone. In addition, the following questions might be addressed:

    To the participants in the parent roles:

    "As the parent in the vignette, what was the major issue/concern on your mind at the start of the interview?"

    "Did this get brought out during the interviews?"

    To both professional and parent:

    "What happened that facilitated this information coming out?"

    "Were there things that hindered the communication process?"

    "What happened that you did not expect, and what happened that you did expect?"

    "What did you learn that can be generalized to your future work as a professional?"

The observer in each group should facilitate the discussion. The emphasis should be on positive and constructive feedback.

Personal reactions to the role play

Please submit a short 1 or 2 page paper summarizing your reactions to this activity. Please use the questions above to structure your comments. In addition, please share any other relevant information.

OBSERVER
"A Frustrating Situation"
The Benson Family

Early interventionist: Laura/Lauren Sellers

Parents: Susan & Ben Benson

Children: Amy, age 14 years
Leslie, age 22 months

The role play vignette takes place between Laura/Lauren Sellers and Susan Benson.

"A Frustrating Situation"

The Benson Family

The Professional's View (Laura/Lauren Sellers*)
You feel angry and frustrated every time you think about the Benson family. Three times this month Susan Benson has missed appointments that were scheduled; two of those times you were simply stood up. It is simply impossible to do home intervention with families like the Bensons. What is particularly frustrating in the Benson case is that it is hard to figure out why things are going so wrong. With some families you just know from the beginning that there will be difficulties; but the Bensons seemed like the type of family with whom you usually have success. Susan and her husband Ben are in their mid-30's; they live in a modest but comfortable home in a middle-class neighborhood with their teenage daughter Amy and their 22-month old daughter, Leslie. Leslie was diagnosed with moderate cerebral palsy when she was 14 months old.

The Bensons were referred to the home-based intervention program with which you are affiliated by their pediatrician. They were cooperative throughout the evaluation process and seemed in every way to want to follow through with the recommendations to work with you on a weekly basis on home programming for Leslie. This seemed to be going well for the first several months, although Susan Benson was not always consistent with the record-keeping and progress reports that you asked her to keep. The problems really began about two months ago, when for one reason or another Susan cancelled several of the weekly appointments; but simply to NOT be home for two weeks in a row was really inexcusable. Doesn't she realize how busy you are, and how many other children desperately need the kind of help you are trying to provide to Leslie? What is really hard to understand is how the Bensons can neglect Leslie in this way. You know she is not getting the home therapy she needs, and you know what that will mean down the line. You have gently explained this to Susan, and she seems to comprehend the importance of consistent physical therapy. You really don't understand how someone like Susan Benson can act so irresponsibly.

After Susan Benson missed the last appointment, you decided to call their pediatrician and report their failure to follow through with the referral. You spoke with the nurse practitioner at the office who said she would call Susan Benson in order to check on Leslie. She said perhaps she could find out why the Bensons were not cooperating. You haven't heard back from the nurse and frankly don't expect to find out much from her. You know that Susan Benson can come up with plenty of excuses over the phone for why she is not doing what she is supposed to do.

You recently attended a professional workshop which raised some nagging questions in your mind about the Bensons. You definitely did not agree with everything presented at the workshop, but some of the information hit home in an uncomfortable way. You realize that you have focused all of your attention on Leslie and Susan with not much thought about Mr. Benson and the teenage daughter. Thinking back on that has called up some occasions when Susan Benson has talked about her teenager in a worried sort of way. You are wondering if you should have paid more attention to the broader family picture. You also realize that the Bensons were given a "hard sell" when it came to recommendations for home programming. Because they seemed like the type of family who would have success with this approach, you didn't spend much time on other alternatives for therapy. You're wondering now if this was a mistake. The problem in some ways is that you were trained to work with children and mothers. Some of these new ideas are complicated and certainly require skills that can't be learned in a one day workshop. One thing that you do feel able to do is listen to parents; in fact, you have always prided yourself in your ability to establish rapport with the mothers in your practice. Lately, you have been so busy you just haven't taken the time to do this.

The workshop and the thinking you did afterwards has inspired you to try again with the Bensons. You decided to implement the following plan:

1. Call Susan Benson and suggest a meeting with the entire family, if possible, at a time convenient for the family.

2. The purpose of the meeting would be to get ideas from the family about where they wanted to go with the home intervention.

3. You suggested that Susan call you back with suggestions for times. You have actually heard back from Susan who suggested a time but also said her husband and teenager would not be able to come. So much for that idea. You are now waiting to see if Susan is home for this visit. You know she can sound cooperative on the phone. Your plan is to use your listening skills to try and get to the bottom of why intervention with the Bensons is not working well. You also might try some of the other skills you heard about at the workshop. At any rate, you hope Susan shows up because you would like a second chance at establishing a working relationship with this family.

**Interventionist could be male or female*

The Parent's View (Susan Benson)
What these therapists don't realize is that there are lots of things going on in your family now in addition to Leslie (aged 22 months), her cerebral palsy and her physical therapy exercises. You know Leslie needs the PT and you have tried to follow the regime recommended, but it's just not possible with everything else that is going on. In fact, at this point Leslie seems to be the healthiest member of the family. Ben's blood pressure has gone sky high; he's on medication, and he's supposed to be on a salt-free, low-fat diet that he hates. His cardiologist says with his health history and current condition he is headed for trouble unless he makes some drastic changes.

Amy is driving you crazy, and you are afraid that she is really going to do something that will ruin her life. She's staying out past her curfew, running around with the wrong crowd, disrespectful and rude to everyone but Leslie; she really seems out of control. You have tried talking to her high school counselor; but with 2000 kids at the school, unless you are pregnant, dropping out, or a genius, they hardly seem to know that you exist. The counselor is no help. You are trying to protect Ben from knowing how worried you are. You have managed to keep him from knowing how late Amy is staying out; but he definitely notices her rudeness and it seems like they're always arguing, which is bad for his blood pressure. You try to keep up a calm front for Ben. It is important for him to relax.

You know you haven't handled things well with Leslie's therapist, Laura Sellers. You find yourself wanting to avoid her because you feel she won't understand why you're not doing the home therapy with Leslie. And deep down you feel pretty guilty about that. But there are only so many things that you can do at once, and right now Leslie is doing a lot better than anyone else. You're really trying to concentrate on Ben and Amy. You hope that once you can get those things under control then you can get back on track with Leslie.

Laura Sellers called again this week, wanting to schedule another appointment. You really did not want to hear from her, especially after getting the call from the pediatrician's office about her calling in about Leslie. The nurse seemed to be implying that something might be wrong with Leslie or with you. All you need is one more person trying to create more problems. You felt like telling Laura that you were going to have to stop even trying to work with her for awhile, but something in her tone and what she said made you give in and agree to meet with her. She said something about wanting to rethink Leslie's intervention plan and wanting to meet with the entire family. The idea of getting Ben and Amy involved seems impossible. Ben needs to be protected from stress, and Amy will hardly talk to adults. But the idea of rethinking the intervention plan sounds like what you have already done on your own. You cannot believe someone as fixed on her ideas as this therapist is willing to rethink anything, but you also realize this experience must be frustrating for her. After all, she is probably used to success because she is clearly competent and knows all there is to know about working with children like Leslie.

You hope you'll be able to make this appointment. The last few times that a visit has been planned, other things have come up and you haven't been able to be home. You feel badly about this, but you have got to stick to your priorities right now and that is to deal with the immediate problems.

OBSERVER

"A Success Story"
The Hatcher Family

The Community Preschool Teacher: Joan/John Smith

Parents: Maryann Hatcher and Ken Hatcher (they are separated)

Child: Tommy Hatcher, age 4 years

The Early Intervention Consultant: Mr. Wise. This person has asked the preschool teacher to make a presentaiton to the school board about Tommy Hatcher's successful integration into the preschool.

Tommy's doctor: Dr. Hayes. The preschool teacher has called her asking for information about Tommy's allergies.

The role play vignette takes place between Joan/John Smith and Maryann Hatcher.

"A Success Story"

The Hatcher Family

The Community Preschool Teacher's View (Joan/John Smith*)
You were really surprised when the early intervention consultant called and wanted you to make a presentation to the school board on your success with Tommy Hatcher. You are not sure at all you want to talk about this family, at least not as a "success". Tommy Hatcher is actually doing quite well. When the early intervention consultant introduced the idea of Tommy attending the Community Preschool (a preschool for typically-developing children) you weren't sure how well it would work. Tommy had never been in a group child care situation because of his mother's concerns about Tommy: his developmental delay due to his early hospitalizations, his severe food allergies, and his asthma. His mother questioned whether he could be accommodated at all in a regular preschool. She had always engaged a babysitter in her home so that she could maintain her job as a computer specialist.

An evaluation conducted at the time of Tommy's referral for placement at your school had shown that although Tommy lagged in fine and gross motor development, he had superior verbal skills and could benefit from the socialization opportunities at the Community Preschool.

A lot has been worked out since Tommy's enrollment six months age. A rule was made that the children could not trade food at snack time and lunch time. Ms. Hatcher, Tommy's mother, volunteered to come in every day to give Tommy his medicine.

In your opinion the real problem is Ms. Hatcher. She is an over-involved, paranoid mother of an only child. She had already caused you untold problems and you do not trust her at all. Ms. Hatcher called five times before the field trip to the nearby bakery to check on the transportation, to see whether there would be any food offered to the children, and to determine how Tommy would get his medicine that day. Then when you called Tommy's doctor to get some more first-hand information about Tommy's medical problems, the mother accused you of going over her head. You were furious. At this point you won't even let the public health nurse do a hearing test on Tommy without the mother's permission. You certainly were not going to talk to the school board about Tommy without written permission from both the mother and the father.

In fact, you don't really have the time to make a presentation to anyone. You have eighteen children to deal with every day; three of them have behavioral problems or developmental delays. Even though you have meetings to go to nearly every afternoon after school, you still don't have enough time to discuss all these children with the early intervention consultant who is supposed to assist you with these children. You never get out of school before three, and you leave your house at seven in the morning. You are allegedly working twenty hours a week, but with "mainstreaming" your hours have gotten longer and longer. You are more than responsive to parents, and it's not unusual for you to get a call from the parents of one of your students at home.

Another school field trip is coming up and you realize that the problems with Tommy Hatcher's mother are going to resurface. You have recently attended a workshop on "Collaborating with Parents" and feel that some of the ideas presented there might help your relationship with Ms. Hatcher. One idea was to use a "proactive" approach. . . that is, to get together with parents as soon as concerns arise, rather than waiting until a crisis occurs. You feel as if the upcoming field trip might be a chance for you to try this approach. You were surprised at how pleased Ms. Hatcher seemed to be at your call. She said she really was anxious to talk about the field trip and other things that were on her mind.

In some ways you are dreading this meeting. It is one more chore in a hectic schedule, and you really are wondering what "the other things" on Ms. Hatcher's mind are. But in other respects you are hopeful about the meeting. You would like to try some of the strategies you heard about at the workshop, and Ms. Hatcher's response to your phone call makes you think that you might be on the right track with her.

1. One strategy that you are going to try is to make a general plan about the meeting. You have already started that on the phone by reaching a mutual agreement with Ms. Hatcher regarding TIME ALLOTTED for the meeting. The last time you had a conference with her it lasted over an hour; this time you both have agreed on 20-30 minutes with another meeting possible if there are still things to discuss.

2. Another strategy is to LISTEN to Ms. Hatcher and to encourage her to generate the solutions to the problems related to the field trip. To do this you might also need to use certain questioning skills. You know from experience that if you start making suggestions right away, none will be acceptable; the workshop confirmed your experiences that your usual approach does not always work. In addition, by listening you are likely to find out what else is on her mind more quickly.

3. A third strategy is summarizing. Ms. Hatcher tends to get lost in detail and often repeats herself (Could this have anything to do with not feeling like she was being heard?) Anyway, you feel you may have to do some summarizing in order to focus the discussion and make sure there is time for all of Ms. Hatcher's concerns to emerge.

**Preschool teacher could be male or female*

The Mother's View (Maryann Hatcher)
What educators don't understand is that what they see at school isn't exactly what's been going on until then. For more than four years you have been struggling, first to keep Tommy alive, and then to keep him from getting sick and being rushed to the hospital. Now he is in preschool, big for this age, and the picture of health. But you know that looks can be deceiving.

Tommy was born two months prematurely. Because his lungs were too undeveloped for him to breathe adequately on his own, he suffered from oxygen deprivation (anoxia) at birth. He was placed on a respirator at the hospital for a month. Now he has difficulties with balance, fine motor coordination, and visual tracking, which may be the result of the complications of prematurity. In addition, he has been plagued with all kinds of food allergies. You had to nurse him until he was two; he had not been able to eat much of anything. And then, just before he was two, Tommy developed asthma and has been on asthma medication ever since.

Tommy has never been in a preschool or intervention program. It always seemed like too much of a risk, given his health problems. When Tommy was three, he had attended Sunday school classes for several months. Once he had to be rushed to the hospital when another child dropped some peanut butter on the floor and Tommy somehow ate some of it. After that experience, you withdrew him from the class. Peanut butter, milk, chocolate, and tomatoes are some of the foods that cause a severe allergic reaction in Tommy. He breaks out in hives and then begins to have difficulty breathing.

These trips to the hospital were harrowing for you. And there were always the veiled suggestions and implications by the doctors that you and your husband had been negligent as parents; that you had not explained things carefully enough to other people in Tommy's environment. You knew that you could explain it all to a teacher, but she could not be around all the time. You could only hope the teacher would believe you and go along with the necessary precautions.

The stresses of caring for Tommy spilled over into your marriage. Your husband found all the attention to Tommy's needs annoying. Arguments became more frequent and intense, until finally you and your husband separated several months ago. You communicate frequently about Tommy, and Tommy spends every weekend with his father.

The decision was made to place Tommy in the Community Preschool with Joan (John*), a very good teacher who had had a lot of success with children with special needs. Tommy would have to stay inside during hay fever season and the school agreed to prohibit the trading of food at lunch and snack for all children to make sure that Tommy did not get anything to eat that he shouldn't. In addition, you volunteered to go to school every day at noon to give Tommy his asthma medication. Because so many alterations in the school's regular routine had to be made for Tommy, you feel grateful that at least they took him.

Now Tommy has been in school for six months, and although the early intervention consultant calls this a success story, you are guarded. You feel that your credibility as a mother is being questioned all the time. For instance, the teacher questioned whether Tommy had to be kept indoors this fall; she said she had never even seen Tommy wheeze. But you know that there's a fine line between Tommy's functioning in school and his being hospitalized for asthma.

Another time the teacher greeted you at school asking if you had noticed that Tommy is a little jumpy after you give him his medicine. You know that she was implying that you upset Tommy when you come to school.

You learned recently that Tommy's teacher had gone over your head and placed a call to his allergist. You don't really know what it was about, but the doctor felt it was serious enough to set up a conference between his nurse practitioner and Tommy's teacher. He also suggested that he needed to write a letter to the school vindicating you. You feel put in the middle and there is not a darn thing you can do about it. Schools just don't realize what parents go through and perhaps they never will.

[This case is adapted with permission from one written by Linda Braun and is published in Braun, L., & Swap, S. (1987). ***Building home-school partnerships with America's changing families***. Boston, MA: Wheelock College. Available from Dr. Susan Swap, Office of Special Education and Rehabilitative Services, Wheelock College, Boston, MA.]

Family Interview Performance Rating Scale

Instructions: After watching a live or videotaped role play vignette, please rate the interviewer on the 1–5 scale in each of the five domains.

Conveying a Listening Attitude through Non-verbal Behaviors

____ 1. Eye contact is inattentive; postures & gestures are tense, unnatural.

____ 2. Eye contact is uncertain; too relaxed or tense.

____ 3. Eye contact is somewhat attentive; generally comfortable although may show lack of variation and facilitation in gestures & posture.

____ 4. Generally appropriate eye contact; comfortable, attentive & appropriate gestures.

____ 5. Eye contact is varied and attentive; natural, comfortable, attentive body movements and gestures in synchrony with client.

Eliciting Parental Concerns and Interests through Verbal Behaviors

____ 1. No active attempt made to elicit information about parents' concerns and interests.

____ 2. Minimal active attempt to adequately elicit from parents their concerns and interests.

____ 3. Some active attempts to adequately elicit parents' concerns and interests.

____ 4. Consistent active attempts to adequately elicit parent concerns and interests.

____ 5. Fully, actively and effectvely elicits all parents' concerns and interests. (There is a sense that the parent is able to express their major concerns and this is what differentiates 4 from 5.)

[The criterion used to define "adequate" is the use of open-ended vs. closed-ended questions or verbal responses that encourage a parent to share additional concerns.]

Understanding Parental Concerns and Interests

____ 1. Ignores obvious concerns, feelings and interests expressed by the parents.

____ 2. Efforts to explore one parental concern and/or inadequate attempts to reflect feelings and paraphrase.

____ 3. Efforts to explore some concerns and interests and/or occasionally reflects parental feelings and paraphrases content with accuracy and sensitivity.

____ 4. Consistent effort to explore a majority of concerns and interests and/or to reflect feelings and content with accuracy and sensitivity.

____ 5. Fully explores, understands and genuinely respects all parental concerns, perceptions and interests and/or establishes parent priority.

[Reflections include an invitation to further explore concerns and interests, even when reflections are inaccurate. There must be an opportunity for the parent to respond or react.]

Solution Development

____ 1. Ignores parent's suggestions or makes no attempt to elicit parent's ideas or information about solutions (i.e., times when events went well, existing resources, etc.)

____ 2. Minimal attempt to elicit ideas and information about solutions and strategies from parent. (This rating would include situations where professionals make recommendations and provide choice to parent without first trying to elicit ideas from parent.)

____ 3. Some attempt to elicit solutions and strategies from parent.

____ 4. Consistent efforts at eliciting solutions and strategies from parent.

____ 5. Fully explores parent's ideas about solutions and strategies and summarizes a plan of action based on this information.

Providing Information (Content)

[This category includes introductory content.]

____ 1. Information provided and/or language used is almost always either judgmental, advice, unclear, incomplete, or reassurances.

____ 2. Information provided and/or language used is, more often than not, judgmental, advice, unclear, incomplete, or reassurances.

____ 3 Information provided and/or language used is sometimes advice, unclear, incomplete, or reassurances.

____ 4. For the most part, information and/or language provided is nonjudgmental, clear, complete, and understandable.

____ 5. Only provides information and uses language that is nonjudgmental, clear, complete and understandable to parent.

Providing Information (Timing)

____ 1. Information provided is almost always irrelevant and/or recommendations made without invitation from parent.

____ 2. Information provided is, more often than not, irrelevant and/or without invitation from parent.

___ 3. Information provided is sometimes irrelevant and/or given without invitation from parent.

____ 4. Information provided is, for the most part, relevant and well-timed in terms of parents' requests and interest in the information.

____ 5. Information provided is always relevant and well-timed in terms of parents' request and interest in the information.

Winton, P. J., & Blow, C. (1991). Chapel Hill, NC: Carolina Institute for Research in Infant Personnel Preparation, Frank Porter Graham Child Development Center, University of North Carolina at Chapel Hill.

Appendix I

Miller Family Story*

I. Referral and Planning to Meet

William "Billy" Miller, a 20 month-old white male, was referred to the special early intervention program by this day-care center. He had been placed in day-care two months ago after a woman from a local church had called protective services about possible neglect in the home. This woman had delivered a Thanksgiving basket of food to the family and had been concerned because no toys were in evidence for Billy and his 6 year-old sister, June. The house was also somewhat unkempt and the parents had appeared (to her) retarded. A protective service worker had investigated and found no concerns related to children's safety or basic care, but did find the level of stimulation in the home impoverished and, with the parents' consent, had placed Billy in day-care. Parents were supportive of the day-care placement, saying they wanted "anything that would help" their son. June, Billy's sister, did not need special services.

At the day-care, Billy appeared passive and fearful. He did not play with toys or other children. Often he stood alone in one corner of the room and cried. He never spoke or used gestures. He did not feed himself and did not consistently eat from a spoon when a teacher attempted to feed him. He appeared frightened and visibly shrank from any contact with staff or other children. He was not a behavior problem, but appeared so inhibited that he could not enjoy or enter into activities. Based on these behaviors, the day-care director referred the Miller family to your agency.

A. Discussion Questions

1. What information would you want to gather in order to proceed with this referral?

2. How would you get that information?

3. What issues are likely to be of concern to this family when the first contact is made?

B. Role Play:

The day-care director has told Louise Miller that you will be calling her about Billy. Conduct a role play of the first contact with this family by telephone. During this telephone conversation you would like to set up a family meeting.

- Assign roles for telephone role play (family member, professional, observers)

- Conduct role play

  Family-Louise Miller: you answer the phone when the professional calls. You act hesitant and uncertain but basically agree with whatever is suggested saying you want to do "whatever will help Billy."

C. Feedback

Consider the telephone conversation from the professionals' and parent's perspectives. What was accomplished by the telephone contact? Were parental concerns addressed?

How do you think Lousie is feeling about the intervention program?

Miller Family Story

II. Identifying Family Resources, Priorities and Concerns and Generating Outcomes

The Miller House was a small "shot-gun" house located on an alleyway behind a garage and sitting between two small warehouses. The narrow front porch of the house sat only a few feet back from the alley and little space was available between the house and warehouse. A few broken toys were in evidence under the porch. Jonas Miller, Billy's father, greeted you at the door.

The Miller front room contained two twin beds, each shoved against adjoining walls and two chairs. A closed fireplace with an electric heater in front of it occupied one wall and a large color television turned to the cable community bulletin board channel sat in a corner. Several battered suitcases were stacked on one bed and in another corner was a pile of dirty laundry. However, the beds were made and the room appeared generally neat. No toys were in evidence.

In the room were Jonas and Louise and Louise's father, Hoyt Jordan. Louise's sister, Edna, peered cautiously from the next room. Jonas and Louise sat on a bed at one end of the room; Hoyt occupied a chair against the opposite wall. You took a seat on the other bed near the parents.

When Jonas introduced his father-in-law, he mentioned that Hoyt had just gotten out of the hospital the previous day. In response, the elderly man began a long description of his medical problems. He was 81, "not bad shape for 81, am I?" and had "high blood pressure, kidney trouble, and sugar." His most recent hospitalization was for a bout of pneumonia, but he said he was now "feeling fine, though I can't get around like I used to." After about 10 minutes of description of various illnesses and treatments, Jonas broke in to say "She's here about Billy, Daddy," and Hoyt quieted down.

In the meantime you counted at least four mice running in and out of a hole beside the fireplace. Although distracted by the mice and the TV, you proceeded with the family interview.

A. Discussion Questions

1. What are your major tasks during this meeting?

2. Do you have strategies for accomplishing these tasks?

B. Role Play:

- Conduct a role play of this meeting

- Assign the following roles:
  - a. Jonas Miller
  - b. Louise Miller
  - c. Hoyt Jordan
  - d. Interventionist
  - e. Observer

- Each person playing the role of a family member should read the description of the family members (this information should not be read by others)

- Role play volunteers sit casually; the observer and others should be in positions to see family members and interventionist clearly

- In role play, emphasis is on practicing communication skills

C. Feedback

Participants will consider the questions on the Self-Analysis and Feedback Form

[This information is to be read by participants who play the roles of family members]

The Miller Family

Jonas

Since the protective service worker came to your house, you have been fearful of having your children removed. You have heard stories of social workers who take children away from their parents and you are not sure that the interventionist isn't trying to do that. You feel vulnerable because you do not have a job. You have never worked outside of doing small odd jobs for your landlord and are not sure you could. You are also very worried about your father-in-law's health. With repeated hospitalizations and the many medical problems, it seems unlikely he will live much longer. Since his social security check is the major income for the family, you wonder how you'll survive after he is gone. Billy's problems appear minor to you, although you know that he is shy. He is also not much trouble, the way other children you've seen seem to be and you like him that way.

The Miller Family

Louise

You have always been very shy around people, but you actually kind of enjoy social opportunities if you don't have to talk much. Since last December when a local church brought some food and toys by for the kids, you have been riding the church bus to Sunday School with the children. The people at the church seem nice and although you don't know her name, one woman always speaks to you and you've begun to think of her as a friend. You were the next to youngest daughter and always felt responsible for taking care of your father and your sister, Edna, who is not quite right in the head. You know that your father can't live much longer and you have wondered about the possibility of getting a job, but think you probably would not be able to work. You know Billy can do more than he shows at the day-care, but you sympathize with his painful shyness. You never felt comfortable around people either. On the other hand, you would really like for him to have the opportunity to get a good education and a job.

The Miller Family

Hoyt

Until 25 years ago, you worked as a farm laborer, but increasing health problems and a fall from a hay loft which left you crippled put an end to your work history. Your social security check enables you to continue to take care of your family along with food stamps and government subsidized housing. You are ill much of the time, although you try to keep a bright outlook, you know that you are frequently irritable. You expect Edna, Louise, and Jonas to stay around the house to take care of you. You have taken care of them and you feel it is only what you deserve. You are worried about your impending death which you believe to be very near and can't understand why all the fuss if being made about Billy.

Self-Analysis and Feedback on Miller Family Interview

1. Did interviewer ask for clarification of purpose, format and confidentiality?

2. Was the opening question related to purpose, but broad and open-ended?

3. Were all family members invited to speak?

4. Did the interviewer develop an understanding of the following:
   a. family's perception of child?
   b. family's definition and understanding of disability?
   c. family's informal and formal support systems?
   d. family ecology surrounding events that are the focus of intervention?
   e. other events that are of interest or importance to family members?

5. What communication strategies were particularly helpful in eliciting this information?

6. Was the interviewer able to effectively identify the following:
   a. priorities for outcomes?
   b. specific outcomes?
   c. family-generated solutions or strategies for achieving outcomes?
   d. criteria for success?
   e. timelines?

7. What communication strategies were particularly helpful in generating this information?

8. As the interviewer in this role play, what would you like to do the same and what would you like to do differently, if given another chance at the role play?

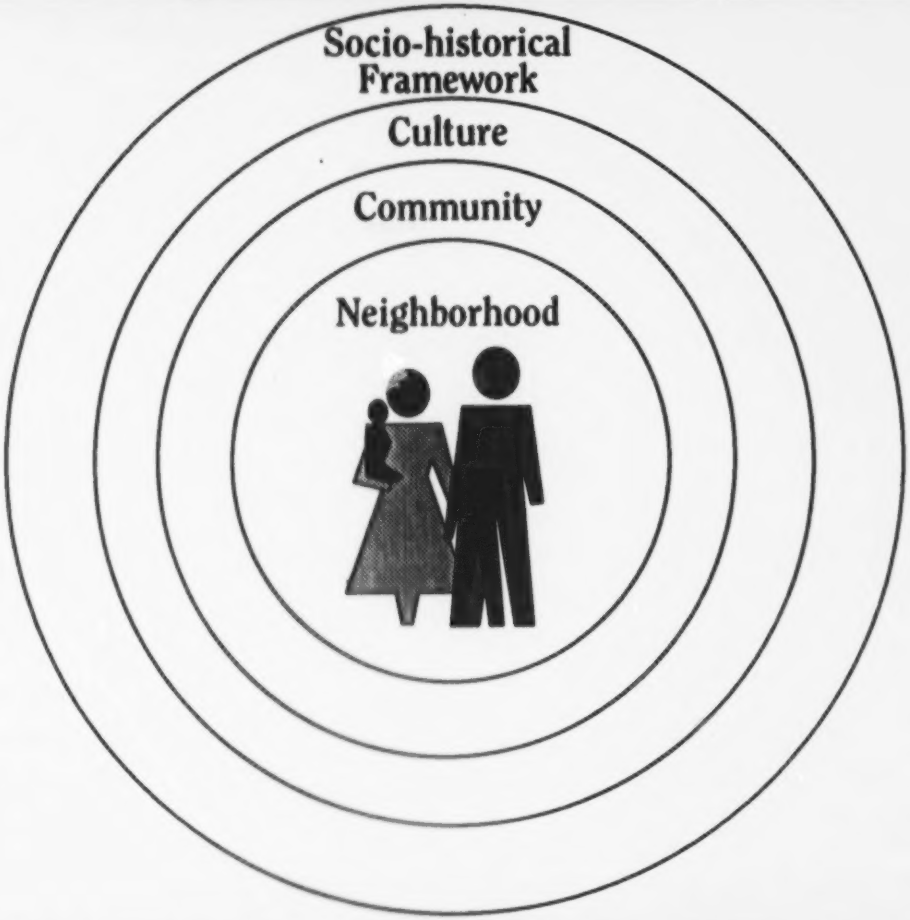
9. As family members, how did you feel about the interview? What part went well? What would you have liked to have been different?

[*This case study first appeared in the following document: M.J. Brotherson, J. Summers, P. Winton, D. Hanna, S. Brady, P. Berdine, C. Rydall & K. Kevi (1989). The IFSP Training Manual. IHDI, University of Kentucky, Lexington, KY. Contact person: Dr. Mary Jane Brotherson, 114 Parter Bldg., U. of Kentucky, Lexington, KY.]

Visual Aids

The following materials can be used to make overhead transparencies or slides to accompany the modules in Section II.

Ecosystem or Ecological Framework



Socio-historical Framework

Culture

Community

Neighborhood

Part H—
Early Intervention Program

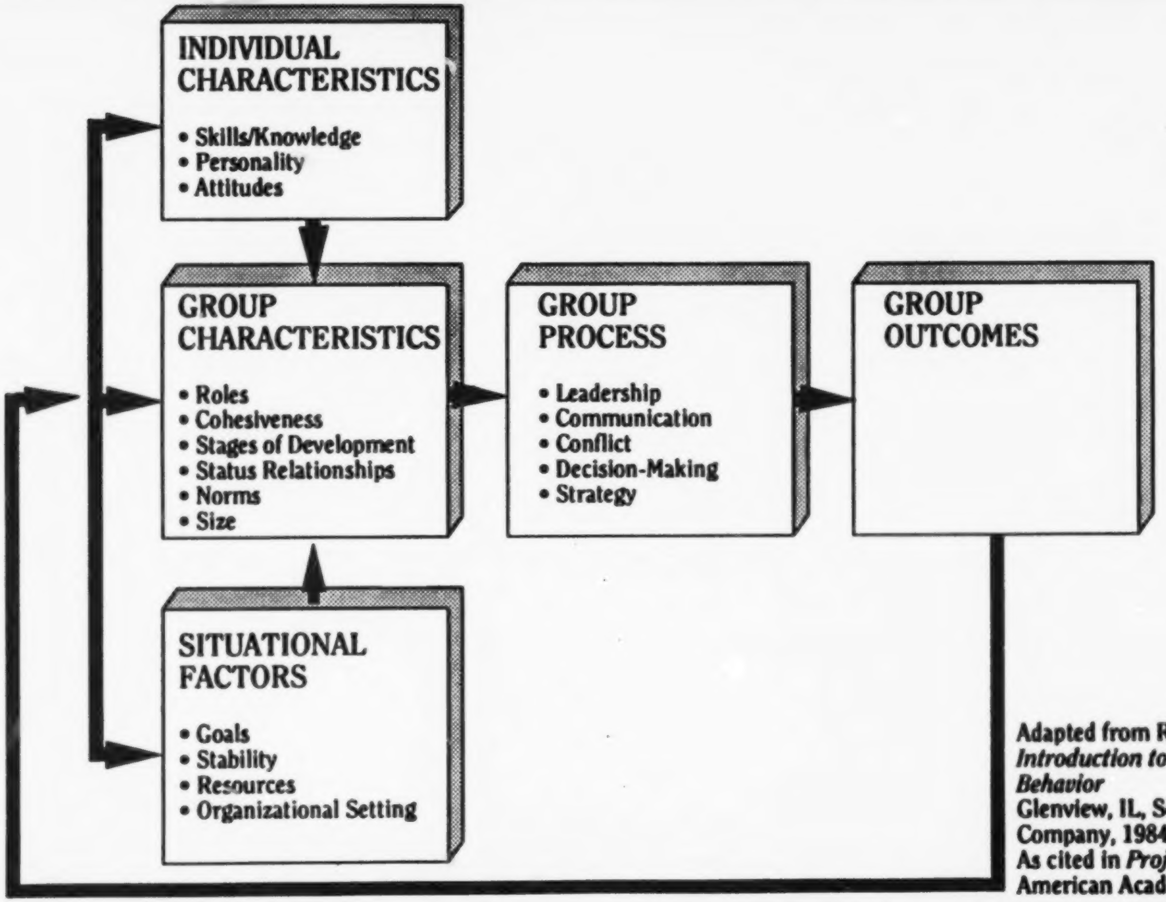
Multidisciplinary Team

special educator, speech/lang. pathologist, audiologist, nurse, OT, PT, nutritionist, psychologist, physician, social worker, the family

IFSP

- Multidisciplinary assessment of child's and family's strengths and needs
- Written plan developed by a multidisciplinary team which **includes** parents or guardian
- Plan must list:
  - **Major Outcomes** expected
  - Recommendations for **Needed Services**
  - Name of **Case Manager**
  - **Criteria, Procedures & Timeline** for **Evaluation**

Team Dynamics and the Decision Making Process



INDIVIDUAL CHARACTERISTICS

- Skills/Knowledge
- Personality
- Attitudes

GROUP CHARACTERISTICS

- Roles
- Cohesiveness
- Stages of Development
- Status Relationships
- Norms
- Size

GROUP PROCESS

- Leadership
- Communication
- Conflict
- Decision-Making
- Strategy

GROUP OUTCOMES

SITUATIONAL FACTORS

- Goals
- Stability
- Resources
- Organizational Setting

Adapted from Richard M. Steers
Introduction to Organizational Behavior
Glenview, IL, Scott Foresman & Company, 1984
As cited in *Project Bridge*
American Academy of Pediatrics

DD

A Framework for Understanding Families

Family Structure

"Who is in the family?"

"What is their connection with one another?"

"What is their connection to those outside the family?"

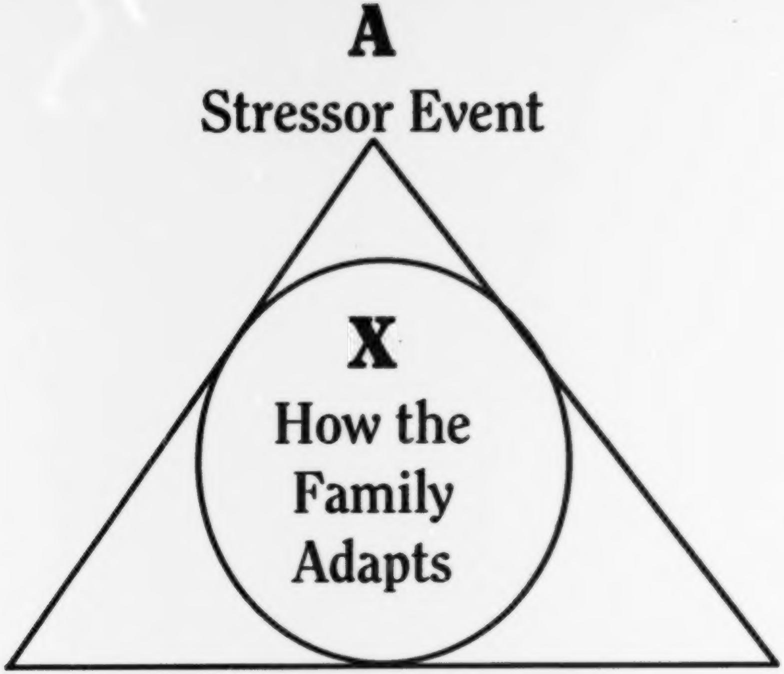
Family Development

"How did the family come to be at this phase in its developmental life cycle?"

Family Function

"How do individual family members actually behave in relation to one another?"

Hill's ABCX Model*



A

Stressor Event

X

How the Family Adapts

B

Family Resources

C

Family Perceptions

Adapted from R. Hill. Social Stresses on the family. *Social Casework*, 39, 139-150. 1958.

Internal Coping Strategies

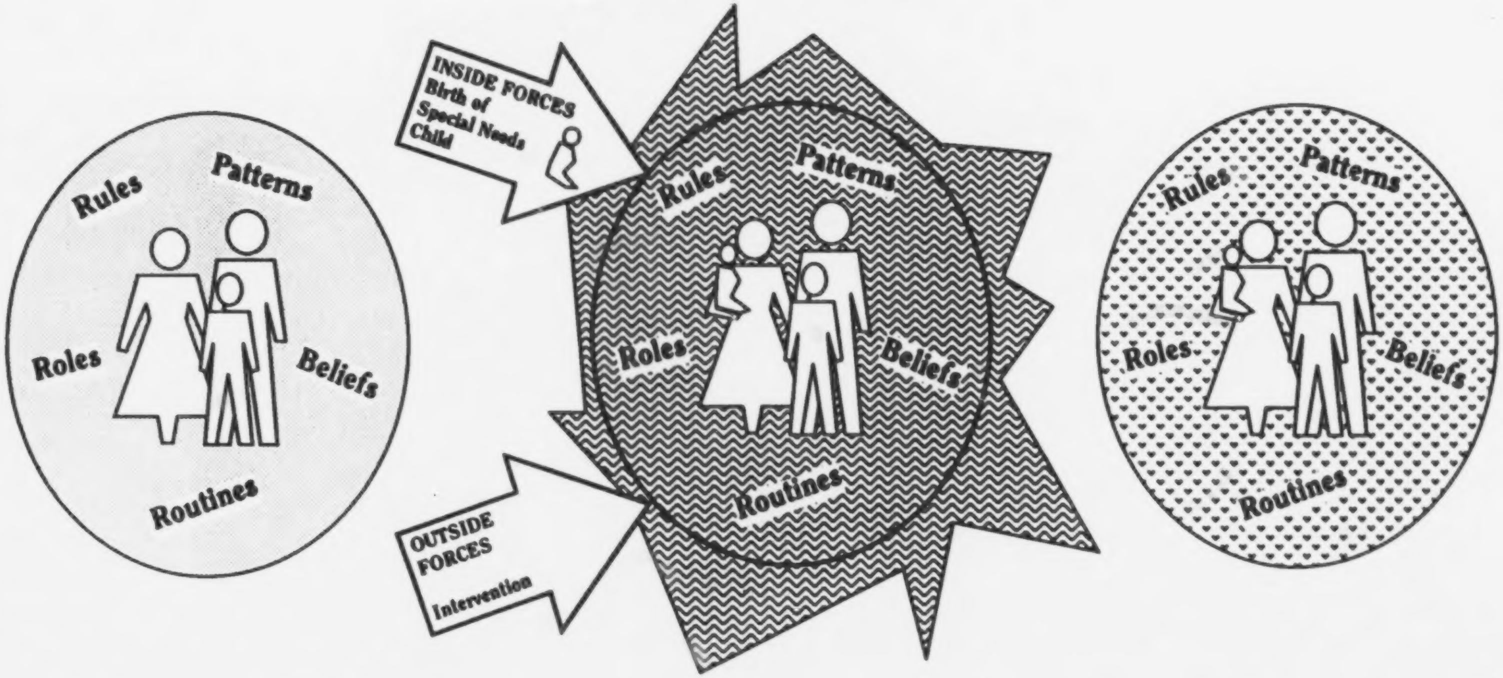
- Passive Appraisal
- Reframing
- Personal, Spiritual, Philosophical Base

External Social Support

- Informal Support
- Formal Support

Process of Adaptability

Resistance to Change



Rules
Patterns
Roles
Beliefs
Routines

INSIDE FORCES
Birth of Special Needs Child

OUTSIDE FORCES
Intervention

Rules
Patterns
Roles
Beliefs
Routines

Rules
Patterns
Roles
Beliefs
Routines

MORPHOSTASIS **MORPHOGENESIS** **MORPHOSTASIS**

Skills for Effectively Communicating with Families

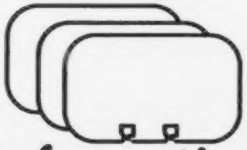
Listening Skills	Focusing and following what a family member has to say
Reflecting Feelings	The ability to accurately and sensitively identify and relfect a family member's feelings
Reflecting Content	The ability to restate the content of a family member's message briefly and concisely
Effective Questioning	Structuring questions in a way that promotes understanding of the family (assessment) and decision making (goal setting)

Family-focused Interview

PHASES OF INTERVIEW:	**PURPOSE:**
1. Preliminary Phase ***Planning to Meet***	• Prepare for family interview by identifying topics that could be covered • Arrange family interview
2. Introductory Phase ***Joining the Family***	• Create an environment where family feels supported • Build rapport with family
3. Inventory Phase ***Understanding the Family***	• Identify each family member's definition of family needs, family strengths, and family resources
4. Goal Setting Phase ***Helping the Family Make Choices***	• Establish family goals & child goals • Prioritize goals • Establish a plan of action for reaching goals
5. Closure Phase ***Saying "Good-bye for Now"***	• Recognize family's effort • Provide opportunity for family to discuss concerns (about the interview process, confidentiality, etc.)

The Name Game

-What is "Service Coordination"?



Information & referral

Data collection & management

Clinical case management

Negotiating complicated institutional systems

KK

Definition of Service Coordination Under Part H

Service Coordination is an active, ongoing process that involves—

(i) Assisting parent of eligible children in goining access to the early intervention services and other services identified in the individualized family service plan;

(ii) Coordinating the provision of early intervention services and other services (such as medical services for other than diagnostic and evaluation purposes) that the child needs or is being provided;

(iii) Facilitating the timely delivery of available services; and

(iv) Continuously seeking the appropriate services and situations necessary to benefit the development of each child being served for the duration of the child's eligibility.

–(*Federal Register,* 54, p. 26311, Sec. 303.6 [a] [3]).

The Service Coorination System in Early Intervention

"A State's policies and procedures for implementing the statewide system of early intervention services must be designed and implemented to ensure that service coordinators are to effectively carry out on an interagency basis the functions and services listed . . . "

(*Federal Register,* 54, p. 26311).

"Functions are not subject to fees. [They] are required functions that must be carried out at public expense by a State, and for which no fees may be charged to parents . . . "

(*Federal Register,* 54, p. 26326).

Family-Centered Practice of Service Coordination in Early Intervention

Part H recognizes the unique and critical role that families play in the development of infants and toddlers who are eligible under this Part. It is clear, both from the statute and the legislative history of the Act, that the Congress intended for families to play an active, collaborative role in the planning and provision of early intervention services.

Thus, these regulations . . . should have a positive impact on the family, because they strengthen the authority and encourage the increased participation of parents in meeting the early intervention needs of their children.

–(*Federal Register*, 54,1989)

Service Coordination Activities in Early Intervention

Service Coordination activities include

(1) Coordinating the performance of evaluations and assessments;

(2) Facilitating and participating in the development, review, and evaluation of individualized family service plans;

(3) Assisting families in identifying available service providers;

(4) coordinating and monitoring the delivery of available services;

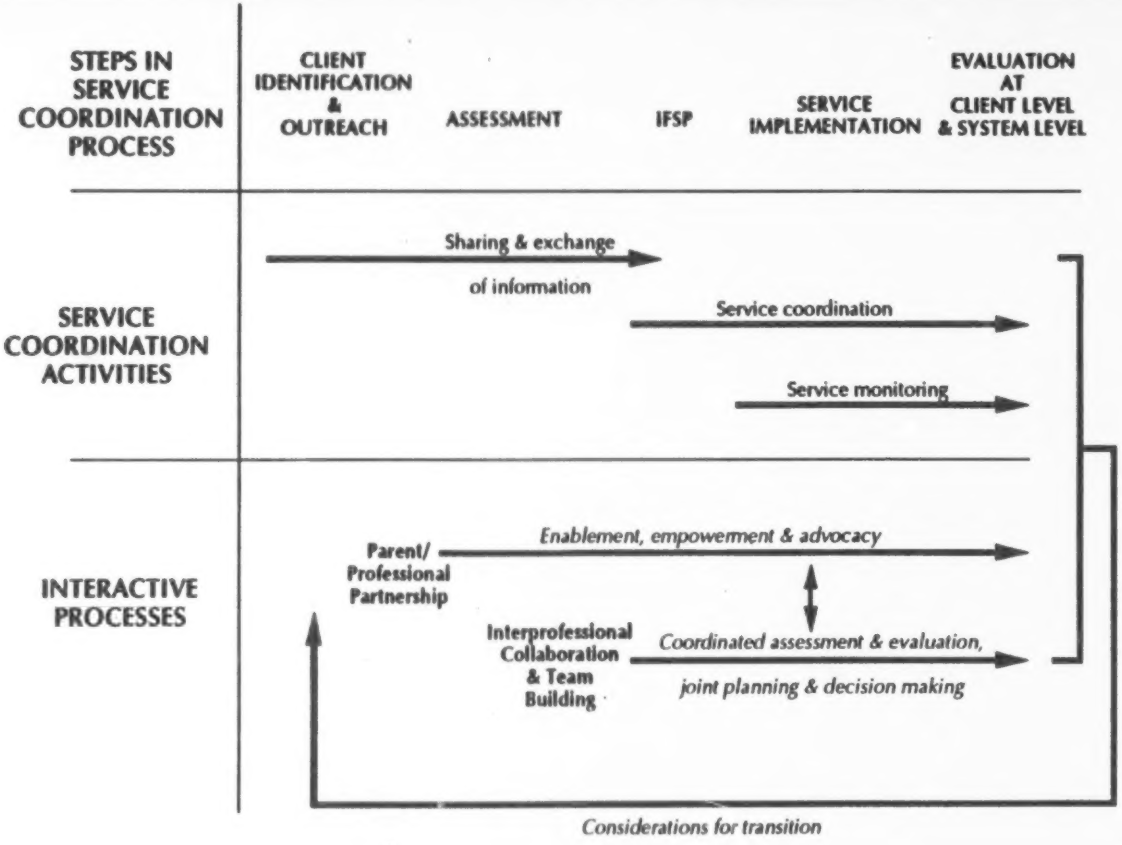
(5) Informing families of the availability of advocacy services;

(6) Coordinating with medical and health providers; and

(7) Facilitating the development of a transition plan to preschool services, if appropriate (Federal Register, 54, 26311).

Service coordination is not a static function, nor is it expected to be the same at every stage of a child's development or for every family. The assistance that a family needs during the neonatal stage of a child's development may be different than their needs later in the child's life... Effective service coordination must be responsive to individual differences and family needs.

The Service Coordination Process in Early Intervention



STEPS IN SERVICE COORDINATION PROCESS

CLIENT IDENTIFICATION & OUTREACH

ASSESSMENT

IFSP

SERVICE IMPLEMENTATION

EVALUATION AT CLIENT LEVEL & SYSTEM LEVEL

SERVICE COORDINATION ACTIVITIES

Sharing & exchange of information

Service coordination

Service monitoring

INTERACTIVE PROCESSES

Parent/ Professional Partnership

Enablement, empowerment & advocacy

Interprofessional Collaboration & Team Building

Coordinated assessment & evaluation, joint planning & decision making

Considerations for transition

Zipper, Weil, & Rounds, 1991
Adapted from Weil & Karls, 1985.

PP

Appendix K

WORKSHEET: Desired Outcomes of Providing Service Coordination

For Children and Families:

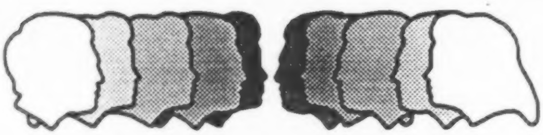
For Service Providers:

For Communities:

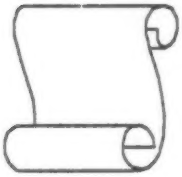
Appendix L

The Great Debate:

Directions for a Group Exercise



Participants will divide into 3 groups and be assigned one of the following positions supporting a particular model or approach to service coordination:



I. RESOLVED: The service coordinator should be employed by the early intervention program, and selected from the discipline most related to the needs of the child and family.

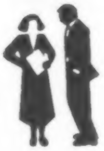
II. RESOLVED: The service coordinator should be independent of the early intervention program. He or she should be a "dedicated" service coordinator (the role is his/her occupation), and employed by a separate agency or private provider.

III. RESOLVED: The service coordinator should be a parent with experience raising a child with special needs. Whether or not the service coordinator is employed by, or independent of the early intervention system, he or she should be a parent, with special training to assume this role.

The Group Task:

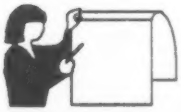
1. Prepare a position asserting the advantages of your model and the comparative disadvantages of your opponents' models. **Remember this is a debate** (probably the only time you do not need to see all sides of an issue)!! Regardless of personal opinions, you must develop a clear argument to support you group's assigned position.

2. Prepare for the rebuttal round by anticipating the short-comings your opponents may raise against your model (however wrong-headed they may be) and think through a good argument.



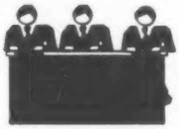
3. Select a spokesperson to represent your group's position in the debate. OK, OK, if everyone is reluctant to do it alone, 2 people could be chosen. Please divide responsibilities. For example, one could present the position and the other could do the rebuttal.

The Great Debate:



Round 1: Positions are presented.

Each speaker (or team) will have 5 minutes to assert the advantages their model has over all others.



Round 2: Rebuttal.

Each speaker (or team) will have 5 minutes to challenge the obviously mistaken ideas presented by their opponents.

Round 3: Large group discussion. (We get to add our "2¢ worth.")

The purpose of the discussion is to add other perspectives, synthesize, and discuss implications for planning and providing service coordination.

Curriculum Materials Evaluation Form

Name: ______________________________

Title: ______________________________

University/Training Setting: ______________________________

Date of field-testing: ______________________________

Within which course/s: ______________________________

Level of course: _____ graduate _____ undergraduate

1. What was your overall reaction to the materials? (Circle one)

1	2	3	4	5
very positive	positive	neutral	negative	very negative

2. Please place a check next to the modules listed below if you used any part of them:

___ #1
___ #2
___ #3
___ #4
___ #5
___ #6
___ #7
___ #8
___ #9
___ #10
___ #11

3. Please rank the extent to which the following components were useful:

Components	**not at all useful**		**somewhat useful**		**very useful**
student objectives	1	2	3	4	5
student activities	1	2	3	4	5
readings/references	1	2	3	4	5
overheads	1	2	3	4	5
evaluation measures	1	2	3	4	5
other curriculum info (background, etc.)	1	2	3	4	5

4. Do you plan to use the materials (in any form) again?

_____ yes
_____ only small portions of materials (please list)
____
____
_____ no plans to use materials again

5. Would you recommend their use for anyone else?

_____ yes (please specify): ______________________________
_____ maybe (please specify): ______________________________
_____ no

6. Please use the back of this sheet for any comments you have related to this curriculum or this topic. Thank you!

Please return to: Pam Winton, Ph.D., Carolina Institute for Research on Infant Personnel Preparation, Frank Porter Graham Child Development Center, CB #8180, UNC-CH, Chapel Hill, NC 27599-8180.